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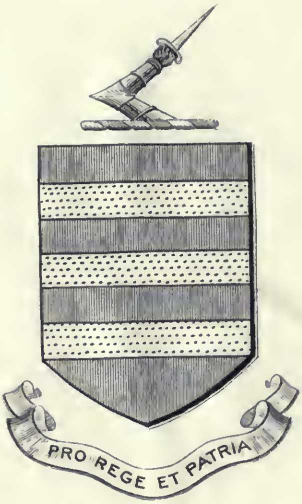

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MEDICAL NEWS.

MDCCCLXXVII.

VOL. XXXV.

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PHILADELPHIA:
HENRY C. LEA.
1877.

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THE MEDICAL NEWS AND LIBRARY.

VOL. XXXV. JANUARY, 1877. No. 409.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on certain rare Forms of Solid Œdema of the Legs. Delivered at the London Hospital, by JONATHAN HUTCHINSON, F.R.C.S., Senior Surgeon to the Hospital.

GENTLEMEN: In connection with several cases which have recently been under our observation, I wish to-day to ask your attention to the different causes of œdema of the legs. Under many circumstances œdema of these parts is connected with a tendency to effusion into the cellular tissue generally, with implication, perhaps, of the great serous cavities also. In most of these it is indicative either of a central impediment to the circulation in the form of heart disease, or of deficient action on the part of the kidneys. There are many other cases, however, in which the swelling of the legs is due to a cause more or less distinctly local, and there are others in which local and general causes each take their share in the result. It becomes of importance, then, and of much interest, to discriminate in each individual case as to the special cause which is at work; and before introducing to you the individual cases, I will attempt an enumeration of the principal groups into which we may classify them.

First let us note the obvious fact that in the lower extremities the venous circulation is at some difficulty, and that if any influence be at work in the body tending to produce transudation of serum from the

Published monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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bloodvessels it will probably show itself first in the feet and legs. Thus it may be convenient to mention, as the first group, cases in which slight passive dropsy occurs in connection with mere debility. This is common enough, and especially so in the aged and in those whose occupations compel them to remain for long periods standing. Although often unattended by any discoverable disease either in heart or kidneys, its occurrence of course always suggests an examination of those organs.

In the second group we may place cases in which the œdema is due to positive impediment in the heart. In these it will almost always be confined at first to the feet and legs, and it will be purely passive —that is, unattended by any inflammatory induration of the parts affected.

In the third group œdema from disease of the kidneys may be placed; and of these cases we may remark that not unfrequently from the first there is swelling of other parts—the eyelids, backs of hands, etc., and very frequently dropsy of the serous cavities.

Of the three forms of œdema just mentioned, it may be said that they are almost always symmetrical and of nearly equal severity in the two limbs. Those which are to follow, however, do not observe this rule, and although any one of them may affect both legs, it is far more common in most of them to observe the symptom on one side only. This onesidedness, of course, attracts our attention to a local cause.

In the fourth group we may include all cases in which the œdema is due to mechanical obstacle to the return of venous blood. The commonest example of this class is in the instance of pregnant women in whom the weight of the uterus, pressing upon the iliac veins of one or both sides, very frequently causes what we may suitably call venous œdema of one or both legs. Ovarian tumours, or any other kind of tumour in the abdomen, may produce similar results. And let me here remark that it is by no means certain that the swelling in these cases will wholly disappear when the cause is removed; for not very unfrequently we observe cases in which repeated pregnancies have at length induced a condition of permanent dilatation of the veins with swelling of the feet. The risk of the œdema becoming permanent is, however, far less than in certain cases which I shall have to mention presently in which local inflammation occupies the chief place as a cause.

In the fifth group we will place all cases in which there is actual disease of the venous trunks. In cases of phlebitis of the main vein of the limb you have seen the extremity become suddenly much swollen and œdematous, and in such cases the œdema will always be, both as regards its extent and its permanence, in relation with its cause. In plugging of superficial veins, we rarely observe any great amount of œdema, and the same remark is true of the numerous cases in which the superficial veins become entirely disabled by varicose dilatation. In these cases the deeper trunks are efficient to carry on the circulation. In connection with this group I must mention the disease known as *phlegmasia dolens*, which has by many been associated, and perhaps correctly in some cases, with venous occlusion. I find it difficult, however, to believe that plugging of veins is the usual cause of this affection; for, if it were, the deep veins would often be obliterated, and the result would be compensatory enlargement of the superficial ones. The phenomena of phlegmasia dolens are far more like those of lymphatic than venous obstruction, and it ought probably to be included in our next group.

The sixth group shall include those cases in which the œdema is wholly or chiefly due to lymphatic obstruction. So little has as yet been made out as to the pathology of the lymphatic system, and so few are our opportunities of post-mortem examination in this direction, that we are obliged to be somewhat less certain in our statements regarding this group than in any other. I do not think, however, that I shall run any risk of misleading you if I ask you to believe that the lymphatic system often takes a large and chief share in the production of œdema, and that it is quite possible for long tracts of the lymphatic tubes to be occluded by inflammatory thickening. I shall have to mention presently one very instructive case in which a whole network of lymphatic trunks in an indurated and cord-like condition could be very easily felt under the skin. In the majority of cases, however, the diagnosis of lymphatic obstruction is conjectural only, and depends to a considerable extent upon the absence of any other satisfactory explanation of the symptoms. In lymphatic cases the disease is almost always non-symmetrical. We may note also, as a curious fact, that very commonly no enlargement of the lymphatic *glands* occurs. I should be inclined to suspect this cause in any case in which the œdema was strictly local and abruptly limited, there being no evidence of disease of the veins or of mechanical pressure. I should consider my diagnosis confirmed if the œdema cleared off without leaving any dilatation of superficial veins, and during the progress of the case I should repeatedly and carefully examine the limb in order to ascertain if any little lines like whip-cord could be felt under it. It is very difficult in many cases to separate solid œdema consequent on obstructed lymphatics from chronic inflammation of the cellular tissue, and in point of fact it is exceedingly probable that the two conditions usually complicate each other. Indeed, it is not unlikely that primary disease of the lymphatics is extremely rare, and that almost always it is secondary to inflammation of the skin and subcutaneous tissues. Modern research has shown that the lymphatic radicles terminate in the areolar interspaces. Hence the facility with which the lymphatic system becomes involved in all forms of inflammation of the skin allied to the erysipelatous.

My last group — the seventh — shall comprise all cases in which the œdema is the result of local inflammation; and these arrange themselves under three heads—those in which the inflammation is allied to erysipelas, those in which it takes the form ef elephantiasis, and those in which thrombosis of venous capillaries, or true purpuric ecchymosis, occurs. The last of these is one of but little importance, and I shall not again advert to it; but the other two are of much interest, and it is with them that I shall be chiefly concerned in the rest of my lecture.

The term "elephantiasis" is now definitely understood to be restricted to those cases of which the common Barbadoes leg is an exaggerated type. It is the *Elephantiasis Arabum*, the *Boucnemia* of Mr. Erasmus Wilson, and the *Scleriasis* of some continental writers. It has nothing whatever to do with true leprosy, to which unfortunately the term *Elephantiasis Græcorum* was formerly applied. Now in all cases to which the term elephantiasis is applicable there is œdema and something more; there is also overgrowth. And here we establish the line of demarcation between elephantiasis and all other varieties of persistent œdema. Prove that the tissues have become hypertrophied, that they are not only sodden with serum, but that they are overgrown, and you prove the right of the malady to the title of elephantoid. It has hitherto been the custom to use this name only in application to the most exaggerated examples of the disease. Nothing can be more injurious to our correct appreciation of the processes of disease than this unfortunate habit. Size ought never to be made a basis for classification; and between the conditions of chronic thickening of skin, with solid œdema and papillary growth, which are not at all uncommon in our out-patient rooms, and the most hideous example of Barbadoes leg which you could find in the West Indian Islands, there is no distinction excepting that of degree; the pathological process is precisely the same in both. The same remark applies to the cases of inflammatory hypertrophy of the labia, which are not uncommon in English practice. In hot countries two forms of elephantiasis are recognized, but they are not wholly distinct, and I believe that not unfrequently one precedes the other. I allude to the tuberculated and the smooth varieties. In the smooth there is much less evidence of growth than there is in the tuberculated, or rather perhaps we ought to say there is less evidence of papillary growth. In the one the skin becomes warty and nodular; in the other, although much indurated, it remains smooth. The tuberculated form rarely affects both legs, whilst the smooth frequently does so. I am told that in India it is usual to consider the smooth form as associated with constitutional disease, and as indicating the necessity for change of residence and the use of quinine; whilst the tuberculated is more purely local. In English practice we meet also with the two varieties. In most cases the tuberculated form of elephantiasis takes its origin from some local injury or local source of inflammation: an ulcer on the leg; an attack of eczema; or, on the genitals, venereal sores may be its starting point. The smooth form, however, begins usually without such cause, and is often set up by a form of inflammation somewhat resembling erysipelas. To this stage the name *Barbadoes rose* has been given. It differs from the common forms of erysipelas in having no abrupt margin and in being unattended by vesications, and, further, in the fact that the fluid effused shows no tendency to reabsorption. The attack is, however, distinctly inflammatory, and it is very probable that inflammation of the lymphatics takes a considerable share in its results. We have in both forms of elephantiasis a very interesting illustration of the results of overfeeding of tissues. Inflammatory disturbance of nutrition is the starting-point. The tissues are flooded with serum, and, owing to their dependent position (scrotum, labium, or leg), this serum has difficulty as to its reabsorption. The cells of the part, already in a state of excitement, feed on it, and irregular modes of growth are the result. You might obtain a somewhat parallel phenomenon, if to any given village unlimited supplies of meat and beer were weekly consigned for gratuitous distribution.

I think I have now said enough to place you in a position to appreciate the cases which I have to relate. I shall not trouble you with any examples of the more common forms of dropsy—these being, indeed, of medical rather than of surgical interest—but shall restrict myself to those of the more unusual forms, preferring such as afford some clue to the nature of the malady.

In the following case we have an instance of immense solid œdema of the whole lower extremity up to the very hip, occurring in a syphilitic patient, as a sequel to a slight bruise of the foot.

On June 28, 1871, I saw, with Mr. Cornelius Garman, of Bow, a very curious case of unsymmetrical persistent œdema. Our patient was a thin, nervous woman, aged about forty-two, the wife of a sea captain. Her left leg, from the pelvis downwards, was enormously swollen, the skin being smooth and brawny. About the foot there were patches of congestion, but in the thigh, where the swelling was as conspicuous as in the leg, the skin was quite pale. The thigh measured five inches more in girth than its fellow, and she assured me that a year ago it had been for a time very much larger than at present. The toes and lowest part of the foot were not swollen in proportion with the rest of the member, the œdema beginning about the instep, and increasing up the left thigh. There was not a trace of œdema in the other leg. Mrs. B—— told us that it had followed from a slight bruise on the instep from a fender. She pointed out to us the exact place of the bruise, and said that inflammation and swelling of the foot followed almost directly after it, although there was no abrasion, and had never been any wound. It was now eighteen months since this slight accident, and although the leg had at times improved it had never returned to its former size. Mrs. B—— complained much of severe aching pain in various parts of the limb; she had never observed any lines of inflamed lymphatics, nor had the inguinal glands ever enlarged. She had repeatedly been obliged to remain in bed for a few days at a time when the swelling was greater than usual, but she would not admit that she had ever derived more than very temporary benefit from the recumbent posture, and asserted that on the whole the limb was better when she walked about. I was told by Mr. Garman that he believed she was accustomed to drink spirits, and that seven years ago he had attended her for constitutional syphilis, some scars of which (rupia) he showed me. Of late years she had not had any symptoms referable to syphilis, and had, indeed, enjoyed good health.

In December, 1872, Mr. Garman was kind enough, in answer to an inquiry, to inform me of the progress of the case. We had determined on a course of iodide of potassium internally, and the local use of an evaporating lead lotion, insisting also on as much rest in bed as possible. The iodide had made her sick, and had been replaced by small doses of mercury, and under these the leg so much improved that it returned to almost its natural size. After remaining well for some months, a relapse occurred, and great swelling was again produced. The patient, at the date of Mr. Garman's letter, was on a voyage to Australia.

In 1873, Mrs. B—— was again brought to me by Mr. Garman, this time on account of a deep syphilitic ulcer on her left arm. Of this she soon got well under the use of iodide and mercurials. Her leg still remained larger than the other, and liable to temporary increase of œdema.

The next case which I shall relate to you is in many respects similar to the preceding one, but it has some features of yet greater interest. We have the same history of constitutional syphilis in the background, and of a slight bruise on the leg as an exciting cause. Then follows a long attack of œdema of one lower extremity, with, ultimately, sudden implication of its fellow. Enlarged and tortuous trunks of lymphatics were easily recognized in the abdominal wall.

Mr. W——, a gentleman of about fifty, was formerly under my care for several years on account of syphilis affecting his nervous system, and took iodide of potassium almost continuously for a very long period. In the beginning of June, 1871, he came to me one day complaining of pain in his right leg. I could find nothing the matter with it, but three days later the whole leg was in a condition of soft œdema, and on the outer part there was the ecchymosis of a bruise. The skin was not in the least cut; it was a simple contusion. On the first occasion he had denied having had any injury, but he now recollected that he had struck his shin in getting into a railway carriage. The œdema was peculiar in its sameness in all parts of the leg, and in the fact that the skin was pale, and had not the slightest trace of congestion. The leg measured an inch and a half more in girth than the other, and wherever pressure was made a deep pit was produced. A few days later he complained of pain up the inner side of the thigh, and we could distinctly trace an enlarged lymphatic cord. A few days after this the whole thigh was swollen, measuring an inch more than the other. He had in connection with this œdema of the leg no special constitutional symptoms. At the end of a fortnight the œdema of the leg had almost wholly disappeared, and that of the thigh had diminished. After this, however, the œdema returned, and I advised that he should have the advantage of sea-air. He went to Ramsgate, and was there under the care of Mr. Henry Curling. One day I was hastily summoned there to see him, as he was in great alarm on account of sudden swelling of the other leg and thigh. For some weeks at this stage both lower extremities were greatly swollen, and he was wholly confined to bed.

On Sept. 10, Mr. W—— returned from Ramsgate. Whilst there he had much improved in health. During the last fortnight of his stay he had omitted the iodide of potassium, and without any relapse of his nerve symptoms. He had been three months there, and during the greater part of the time had been able to get out in a Bath-chair, but not to walk. At one time, about a month before his return, the swelling had wholly disappeared from his right leg, and after he had been a fortnight free from it, it again suddenly returned. On one occasion some large patches of erythema appeared on the left leg; he had also had great irritation in the skin of the legs. His condition at the time of his return was as follows: Both lower extremities very greatly swollen, below the knee distinctly œdematous, so as to pit deeply, but above the knee hard and brawny; some congestion of patches on the left side, and a number of spots, probably the result of scratching. The swelling ended at his hips, and the upper part of his trunk was quite free from it. On the lower half of his abdomen, in the subcutaneous tissue, several hard cords could be felt. These could be traced in some places for six or eight inches in length; they appeared to be as large as crow-quills. The question was, were these lymphatics or veins? No discolouration over them could be detected, but he told me that some weeks ago the skin had been red. Their great hardness, and the knotted unevenness of their surface, seemed to me almost conclusive as to their being lymphatics, and against the conjectured existence of phlebitis. I must note that none of the superficial veins, either of the thighs or abdomen, were visible, nor could I detect anything peculiar along the course of the veins in Scarpa's triangle. We must, however, make some allowance, in respect to the latter point, for the brawny condition of his thighs, which prevented more accurate examination. I cannot believe that phlebitic thrombosis could cause such persistent œdema of the legs without being attended by enlargement of the collateral channels, and of this there was not the slightest trace.

As Mr. W—— was naturally anxious at the protracted duration of his symptoms, I suggested a consultation with Mr. Hilton. We met on Sept. 14. Mr. Hilton agreed with me that the enlarged trunks felt in the abdominal wall were lymphatics, and not veins. After this Mr. W——'s symptoms continued to improve. In the course of a fortnight he could walk about, though the limbs were still somewhat swollen. During October some cord-like lymphatic trunks again appeared on the inner side of his right thigh, where they had been noticed in the first instance; but they had subsided in a week or two. In the beginning of November, 1871, the lower extremities had almost returned to their former size, and he was going about moderately. He was still unable to put his boots on, and wore loose cloth ones. The network of lymphatic trunks which had been for so long present over his left hip could only be felt here and there. A brawny condition of the backs of his thighs and soft œdema of the ankles, etc., had been his last symptoms.

As regards treatment, we had been giving him a rather active saline diuretic throughout. It had agreed well with his stomach, but had not produced any material diuresis. It is very possible that it had no share in the cure; but I may note that, when, after our consultation, we substituted it for a few days by the chlorate of potash, the legs swelled more. Mr. W—— throughout spent his time on a couch, with the feet elevated so as to be much higher than his trunk. We had his bed lifted in a similar manner. Whilst the legs were at their worst he got no benefit from bandaging; it was tried on several occasions, and each time laid aside, as it irritated the skin and produced local swellings. When, however, œdema of the ankles and feet was the only remaining symptom, we used bandaging at night with benefit, disusing it in the daytime.

November, 1872. Mr. W—— is in good health, and able to take exercise freely. I cannot, however, assert that he is wholly free from œdema about his ankles. I have never seen him without some slight evidence of pitting, and if he falls out of health it increases. He still takes tonics frequently, and has had every advantage which change of air and long residence at the seaside could give. The fact that his œdema still persists may, I think, be instructively kept in mind when we have to investigate some of our other cases in which implication of the lymphatics was not proved. In Mr. W——'s case there can, I think, be no reasonable doubt that lymphatic obstruction was the chief cause of his symptoms.

August, 1876. The above report as to Mr. W——'s health and the local condition will still apply. He is obliged to wear elastic stockings, but is otherwise well.

In January, 1872, I saw, at the request of Mr. Disney Thorp, of Malden, and in consultation with my friend Mr. Abernethy Kingdon, a gentleman whose case in some features resembled that of Mr. W——. Our patient was sixty years old, tall, and rather stout. He had been accustomed to take a great deal of exercise, and had several times had his legs bruised.

Eighteen months before I saw him he had suffered from what was considered to have been phlebitis of the deep veins of the left leg, which caused œdema, which persisted for a long time. At length it passed off almost completely, and after an interval his right leg began to suffer in a similar way. When I saw him his right leg was considerably swollen, and his left scarcely at all; and I could not but be struck with the resemblance of his history to that of my patient Mr. W——. Had it really been phlebitis? I could find no corroboration for this suspicion, for the superficial veins were not in the least enlarged. I must admit, however, that I was equally unsuccessful in proving any implication of the lymphatics. After his return home our patient made a perfect recovery. In November, 1872, Mr. Thorpe wrote to me that he was quite well, and able to hunt and shoot as usual.

I show you a photograph representing the state of legs in a man who was under care for a short time in this hospital about a year ago. You will see that the œdema is wholly confined to one leg, which is increased to at least twice the size of the other. The skin was somewhat thickened and hypertrophied, but the main cause of the swelling was œdema. He had suffered from the affection for several years, sometimes better and sometimes worse, but never well. There was no evidence of venous obstruction. We took him into the hospital, kept him in bed, and bandaged his leg, and in the course of ten days he was so much relieved that he insisted on going out. He said that on several former occasions he had obtained great benefit in a similar way, but that it was always merely temporary. His general health was good, and he attributed the attack, if I remember rightly, to a bruise.

I have next to mention two cases which may, I think, be very suitably compared together. One of them I shall be able to show you, as she is at present in the hospital. The other, whose case I will narrate first, is a young lady whom at intervals I have seen occasionally during the last five or six years. She is a patient of my friend Mr. Square, of Plymouth. Her age is about twenty-four, and she has suffered from her remarkable malady for the last ten years. Both legs are affected, and are in the condition of smooth elephantiasis; both forearms are also, though in a much slighter degree, enlarged in the same manner. Her feet are comparatively little involved, owing, probably, to the support given by her boots. The hypertrophy above the tops of the boots is very great, the legs being at least twice their natural thickness. This statement applies to her condition when I first saw her. In August, 1871, when I visited her in Plymouth, the state of things was considerably better, although it had then, she said, somewhat relapsed. One and the principal measure of treatment had been to send her to a more bracing air. During an eighteen months' residence in Scotland her general health had been very good, and the size of her legs had very much diminished. After a few months' resumed residence in Plymouth, she again began to feel weak, and the elephantoid condition began to increase. We had, of course, attended carefully to bandaging the legs, and tonics in various forms had been administered during long periods. A remarkable fact in this case is that Miss ——'s mother and grandmother had, as I was informed, both suffered from a similar disease in girlhood, and in both got rid of it as they advanced in years. None of Miss ——'s brothers or sisters had shown any tendency to it. Miss ——'s mother spoke in the strongest terms of her own experience of the relaxing effects of Plymouth air, stating that she, like her daughter, never felt well except when in a more bracing climate. In India, where smooth elephantiasis is common, it is generally met with in the natives of valleys which are damp and warm.—*Lancet*, August 26, 1876.

HOSPITAL NOTES AND GLEANINGS.

Œdema Glottidis from Drinking Boiling Water; Tracheotomy; Recovery.—A healthy boy, æt. 5, was admitted into Westminster Hospital on September 30, at 3.30 P. M. Two hours before, he had sucked some boiling water from the kettle on the hob.

On admission, the boy's lips were blanched and blistered, his tongue was swollen, and the uvula and tonsils were also swollen—the former looking watery and semi-transparent from the exudation of serum into its tissues. At that time his breathing was tranquil, but it gradually became stridulous. By 7.30 it was markedly so, and there was then retraction of the lower regions of the thorax and decided dyspnœa. At eight o'clock he had a sudden accession of dyspnœa. He jumped up, grasped his neck, gasped for breath, and became quite tallowy in colour. In this emergency tracheotomy was immediately called for, and as there was no time to send for the surgeon, the operation was performed by Mr. Cane. Boy chloroformed. Incision about two inches. Isthmus of thyroid probably divided. Spouting from one small artery secured by bull-dog forceps; subsequently the vessel twisted, and gave no trouble. There was also very slight venous bleeding, but nothing which required ligature. Bivalve tube used, and a fenestrated inner tube. The boy's distress was immediately relieved. He was placed in a separate ward, a blanket awning was placed over the upper part of his bed, and vigorous steaming was kept up. He slept well. Some frothy mucus escaped from the tube during the night.

Oct. 1. Respiration natural. Frothy mucus still escapes from the tube. Temperature 101°; pulse 120. He has swallowed some iced milk and sucked a little ice. Tongue and fauces not so swollen as yesterday.

2*d.* Tracheal wound satisfactory. Tongue less swollen. Large white patches of shedding epithelium appearing on it. Temperature: morning, 100.2°; evening, 100.5°. Has had one ounce of brandy in twenty-four hours, in addition to iced milk and beef-tea.

3*d.* Whilst the inner tube was removed for cleansing, and some fresh tapes were about to be applied to the bivalve outer tube, the latter was suddenly coughed out, and the boy had severe dyspnœa. Quiet again after reintroduction.

10*th.* Tracheal wound, etc., satisfactory. Tube corked to-day for the first time. There was a little noise, but no distress and no recession. For the last three days temperature has been 99°. Boy's tongue and fauces are quite healthy now; he is looking pale and wasted, though he continues to take his food well. Steaming continued, but curtain removed.

14*th.* Tube finally removed.

From this time the boy became rapidly convalescent. The external and tracheal wounds healed without any trouble.

Remarks.—From the swelling of the fauces and the destruction of epithelium of the tongue, there is no reason to doubt that the boy did get some hot water into the back of his mouth. The stridor and dyspnœa, which were very carefully watched for, and which became marked five hours after the accident, were probably due to œdema of the arytæno-epiglottidean folds. This œdema might have been caused by extension from that of the fauces; but, coming on so soon, was more likely due to contact of hot water actually swallowed. It is instructive to notice that at no period in this case was any membranous exudation formed. Mr. R. W. Parker has shown[1] in a summary of such cases that membranous exudation is by no means a common phenomenon in scalds of the glottis; and he has raised the question whether the occurrence of membrane is not due to the entrance of the specific diphtheritic poison over and above the inflammation following the scald. The boy's life was doubtless saved by the promptitude with which tracheotomy was performed. With a mechanical obstruction—which, practically, this amounted to—emetics would have been perfectly useless; and probably leeches, scarification, and ice-bags to the neck, would have been inadequate. The operation showed what surgeons are now familiar with—that the fear of cutting through the isthmus of the thyroid is a bugbear. The result was so satisfactory that it seems almost ungracious to ask whether the tube could not have been removed sooner, and so prevent the risk (especially with a bivalve) of ulceration of the trachea. The question of vigorous steaming is still a disputed point in the after-treatment of tracheotomy. Sir William Jenner believes in gently steaming the room, but not steaming the bed. It is certain that tracheotomy cases have made capital recoveries without any steaming at all, especially where there has been no membranous exudation. But if there is membrane formed, steaming probably promotes a mucous discharge, and facilitates the removal of the membrane.—*Med. Times and Gazette*, Nov. 18, 1876.

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[1] Clinical Society: "Scald of the Glottis, with Membranous Exudation." 1875.

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Dislocation of Femur upon Dorsum Ilii reduced by Manipulation.—A strong, muscular man, who had fallen 24 hours previously and dislocated his right hip, was brought before the clinical class of Bellevue Hospital. The patient resting pretty fairly upon his back, Dr. F. H. Hamilton, standing upon the right side of the patient, *first*, took hold of the dislocated limb (which was large and powerful), by placing the palm of his left hand under the knee, and grasping the top of the ankle with the right hand. The leg was brought to a right angle with the thigh, and the thigh flexed to a right angle with the body—the whole limb being still in a position of adduction and inward rotation. When the thigh reached the position of a right angle with the body, there was evident resistance, indicating that it could be carried no further in this direction without the application of considerable force. *Second*, the thigh was abductod moderately, or as far as it could be carried without force. Attention was called to the fact that even this amount of abduction was impossible when the thigh was in the position which it occupied before the manipulation was commenced; but the abduction did not exceed eight or ten degrees, and was not sufficient to elevate the thigh to a perpendicular line —indeed it was considerably short of this position. *Third*, the whole limb was rotated outwards; and here was the first point of delay in the process of manipulation. During a few seconds no further progress was made toward reduction; but the position was steadily maintained by continued forcible rotation outwards. Dr. Hamilton remarked that he felt no yielding of the bone; but this observation had scarcely been made, when the head suddenly slipped into its socket, and the limb fell, with a peculiar oscillating motion, upon the table, parallel with the sound limb.

Dr. H. remarked, "this method is probably very old. Hippocrates described very briefly how we might sometimes reduce a dislocation of the thigh, by bending the limb at the joint and making rotation; and many other surgeons, from time to time, have, more or less perfectly, described this mode of reduction; yet it was so little known to surgeons generally, that even Sir Astley never alluded to it in his Treatise on Dislocations and Fractures near the Joints, nor in any of his other writings. Professor Nathan Smith, of New Haven, practised this method; and in the volume published by his son, Professor N. R. Smith, of Baltimore, the method is described with great fidelity, and is illustrated by drawings. Notwithstanding all this, to the late Dr. Reid, of Rochester, N. Y., the profession and the world are indebted, mainly, for our present knowledge upon this subject; since he again drew our attention to it, and succeeded in demonstrating, to the complete satisfaction of all, by a number of cases, its great superiority over every other method. When, however, he was reminded that Dr. Nathan Smith had described and practised the same method, that many others had done the same, and that he could not, therefore, claim, strictly speakly, the original discovery, he refused to concede this point; claiming that Nathan Smith had directed the limb to be carried up abducted, which, he affirmed correctly, was impossible; but he evidently misunderstood Dr. Smith, who had only said that the thigh must be *slightly* abducted, by pressing the knee outwards while it was being flexed; and this advice was given in order that the head of the bone might be kept near the posterior lip of the acetabulum. This may be, and we think it is, unnecessary, but it does not affect in any way the principle of the reduction.

"I wish to call your attention again to

the fact that, in effecting reduction, the thigh was only moved in those directions in which it could be easily moved. It could not, at first, be abducted or adducted, or extended. In all these directions it was nearly or quite immovable. It could, however, be flexed easily to a right angle with the body; and this was the first thing done. Dr. Read declared that the thigh must be flexed until the knee touched the belly; but I have never found this degree of flexion necessary, except in old dislocations. Nor is it proper, in recent cases, to make this extreme flexion, unless moderate (right-angled) flexion has failed, since it increases the laceration of the capsule, renders liable a displacement of the head of the bone into the foramen thyroideum, and endangers a fracture of the neck of the femur. When the thigh-bone had arrived at a right angle with the body, a slight abduction became practicable; and now the head of the femur, situated behind the acetabulum, was ascending the inclined plane towards its posterior lip or margin. Steady and forcible rotation outwards, of the knee and thigh, finally carried the head into the socket. This might have been facilitated by lifting the knee, or by a slight rocking motion, as first described by Nathan Smith; but neither of these aids were described in this case."

Before the patient was removed, a small pillow was placed between the knees and the legs loosely tied together, to prevent a re-luxation.

On the fourth day afterwards the man walked without limping, and declared he felt no soreness or pain in the thigh.—*Medical Record*, Dec. 2, 1876.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Yellow Fever in Savannah.—We have been favoured with a copy of the *Savannah Morning News*, of Nov. 28th last, which contains a record of the interments from all diseases which took place during the months of August, September, October, and November. We extract the following condensed summary.

	Total Deaths.	Yellow Fever.	Other Dis.	Whites.	Blacks.
Aug.	172	33	139	91	81
Sept.	783	556	227	575	208
Oct.	474	287	187	301	173
Nov.	145	64	81	91	54
Total	1574	940	634	1058	516

There is, besides, a record of the deaths of 22 persons who died in the city and were buried elsewhere, or who contracted this disease in Savannah, but who died and were buried elsewhere. The great mortality from other diseases than yellow fever is remarkable, and may be partly accounted for by the suggestion that some of the deaths attributed to other diseases were really due to yellow fever.

The manner in which the disease was introduced into Savannah has not been satisfactorily shown; by some it is supposed to have been introduced directly by vessels from Havana, by others indirectly from Brunswick. Dr. Geo. H. Stone, of the Marine Hospital service, in his report to the Supervising Surgeon at Washington, does not satisfactorily clear up this point. He gives us, however, the following facts:—

"The Atlantic and Gulf Railroad wharf is situated on the river to the northeast of the city. The immediate surroundings are lowlands, most of which are under dry culture. The earth which makes the wharf is ballast that has been unloaded from vessels at this point. The first cases of yellow fever during this epidemic all point in this direction, and I am firmly convinced that the disease started from this location, whether imported there or not." . . . .

"It has been the custom of Spanish vessels arriving at this port to take a cargo from Spain or New York to Havana. After discharging the cargo the vessel takes in her ballast, the soil of Havana or vicinity. This soil, from the hotbed of yellow fever, is spread upon the river front of the Atlantic and Gulf Railroad wharf. Is it not probable that this ballast (which is composed of soft rock and sand) may contain the deadly poison in its embrace, to be developed and propagated when the climatic influences are favourable to its growth?"

In commenting on the type of fever he remarks: "Black vomit has not been necessarily a fatal symptom, many cases with this symptom having recovered. Vomiting of blood in large quantities has not been uncommon; blood and black vomit by stool has been observed; dark-green and black urine has been noted; yellow urine and dark-red urine was very common. In fatal cases, abundance of albumen was found by me in the urine; albumen in the urine has not, however, been a constant symptom; the body was always yellow after death, and the liver invariably presented the peculiar box-wood colour."

—

Yellow Fever in Baltimore.—The editor of the *Baltimore Physician and Surgeon*, in his number for November last, states that "The recent epidemic of fever that visited the southeastern section of Baltimore, contiguous to the water-line, about the middle of August, and continued for a little over two months, was certainly *yellow fever*." "We believe," he adds, "that nearly every physician who saw the disease concurs in the above opinion; and some of them, we are informed, invariably assigned yellow fever as the cause of death in their burial certificates; but these cases were as invariably suppressed in the published weekly reports from the Health Office."

This deception is attempted to be justified on what appears to us to be very unjustifiable grounds.

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The International Congress and what is said of it.—The reports of the delegates from the Royal Medical and Chirurgical Society and of the Pathological Society of London have reached us, and from them we make the following extracts:—

The delegates of the Royal Medical and Chirurgical Society of London reported (*Lancet*, Nov. 25, 1876) that "although scientific gatherings so constituted often find it difficult to sustain the due state of philosophical abstraction from competing social attractions, the meetings were marked by the most earnest and steady attention to the business throughout."

"Judged by the elevation of tone, and ability displayed in the addresses, by the selection of topics for discussion, by the learning and masterly grasp by which the memoirs were distinguished, by the numbers and prominence of the men who led the discussions, and by the scientific yet practical value of the results, the great Medical Congress of Philadelphia must be pronounced a splendid success, deserving to be remembered as an epoch, not alone in American, but in cosmopolitan medical history.

"All this, knowing as we do the great position held by our American brethren in the medical world, might have been predicated with confidence. It may seem superfluous for us to say it, but strong feelings will have utterance. We cannot refrain from expressing our admiration for the completeness and harmony of the conception and design of this Congress, and for the strength of purpose and working skill with which the whole was carried out to the full realization.

. . . .

"We cannot conclude without attempting to convey to you, Mr. President, and through you to the Society which it was our good fortune and privilege to represent, how warmly we appreciate the unceasing exercise of all those marks of thoughtful kindness and consideration so grateful to visitors in a strange country, which were so successful in making us feel we were at home, and which contribute so much to make up a store of pleasant memories."

The delegates of the Pathological Society of London conclude their report to the Society (*Lancet*, Nov. 25) with an expression of the increased admiration the delegates had gained for their American brethren, "whose zeal, intelligence, and energy are only equalled by their warmth of reception, and their unbounded hospitality." The report was ordered to be printed in the *Transactions* of the Society.

The following extracts from the medical press correctly represents, so far as we can learn, the verdict of the profession in this country:—

"The meeting of the International Medical Congress was in every respect a most gratifying success. The Congress was representative of some of the highest professional talent of the most civilized nations of the globe, and the proceedings were marked throughout by harmony and good feeling, and by a determination to make the best possible use of the few days devoted to friendly business intercourse. The good results of the Congress cannot be estimated by the actual work done during the session, large and satisfactory as it was. For many years to come the personal association of so large a number of distinguished members of the profession will exert a benign and stimulating influence on every department of medicine and surgery, and be the means of disseminating broader and more liberal views among the rank and file of a class of hard-working men, whose calling is, of all others, the most thoroughly cosmopolitan in its aims and aspirations."—*New York Medical Journal*, Oct. 1876.

"The Congress was a superb success.

"It was the most successful, earnest, enjoyable, and, above all, the most scientific medical gathering which ever met in America. The addresses have been worthy of their distinguished authors, and the papers and discussions have enriched science. The tone of the meetings has been scholarly and dignified. We feel that the physicians who designed it may well be proud of their celebration of our national anniversary."—*Boston Medical and Surgical Journal*, Sept. 14 and 21, 1876.

"Undoubtedly this was the most important of all medical assemblages that have ever been held on this continent. . . . An impression is left behind that will profitably influence medical opinion and practice here for a long series of years."—*Virginia Medical Monthly*, Oct. 1876.

Medical Graduates in California.—At a commencement of the Medical Department of the University of California, on the 1st of Nov. last, the degree of M.D. was conferred upon twenty candidates, and at a commencement of the Medical College of the Pacific upon twenty candidates.

FOREIGN INTELLIGENCE.

Chorea Minor treated successfully by Means of Injections of Hydrate of Chloral.—Drs. Goltz and Auger give the details of an obstinate case of chorea minor in which eserin and the subcutaneous injection of morphia had been tried without success, and in which they determined to try the effects of clysters containing chloral hydrate. This drug cannot well be employed by subcutaneous injection on account of its tendency to produce local irritation, whilst when taken in the form of syrup it occasions nausea; when injected into the large intestine, it does not produce any remarkable sensation of burning nor any secondary symptoms. They commenced with the administration of 45 grains of chloral twice a day in the form of an enema. Only slight improvement occurred at first, and they increased the dose to 60 grains twice a day. Under this treatment complete recovery took place in fifteen days, which was not followed by any relapse.—*Practitioner*, December, 1876.

On the Treatment of Pityriasis Capitis by means of Solutions of Hydrate of Chloral.—M. L. Martineau (*Bull. de Thérap.*, xl. p. 39) employs a five per cent. solution of hydrate of chloral in pityriasis capitis, one or two teaspoonfuls of the fluid being warmed and applied by means of a sponge. It should be well rubbed in, and the skin should not be dried. The itching and desquamation soon cease. It is advisable to continue the application every day for a month. When the disease is complicated with erythema or papular eczema, he adds five per cent. of the liquor hydrargyri bichloridi to the above fluid, and after the complication has passed off he returns to the simple chloralized solution.—*Practitioner*, December, 1876.

Internal Applications of Tincture of Eucalyptus in Gangrene of the Lungs.—M. Bucquoy states (*Med. Chir. Rundschau*, April, 1876) that whilst he has been unable to corroborate the favourable results obtained by others from the action of the tincture of eucalyptus in catarrhal conditions of the bronchia, and in bronchorrhœa, he must nevertheless recommend it on account of its stimulating and disinfecting qualities in gangrene of the lungs. During the past five years he has had yearly from two to four cases of gangrene of the lung in his hospital at Cochin, and of these five cases recovered. Even in the fatal cases it improved the smell of the breath and sputa, and the cough became milder and less constant. One case treated for two months was cured. The croupous destruction of the lungs was here limited by slight pleurisy. The dose is half a drachm.—*Practitioner*, December, 1876.

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Sudden Death after Thoracentesis.—The French physicians are equally puzzled with the English ones to explain in all cases the cause of sudden death after thoracentesis. At the meeting of the Society of Biology, on November 18 (reported in the *Gazette des Hôpitaux*, November 21), M. Leven gave the details of one of these cases, and showed, both from the symptoms and post-mortem appearances, that his patient had not succumbed either to pulmonary congestion, cerebral anæmia, or syncope. By elimination, M. Leven was led to attribute the fatal issue to a "bulbar irritation which had its origin in the irritation of the nerves of the lung, especially the vagus." This "reflex" explanation, it will be remembered, was one of the theories discussed in Dr. Cayley's case recently read before the Clinical Society; but in Dr. Cayley's case iodine injections had been used. M. Charcot, at the meeting above mentioned, referred to a patient the subject of gout, and who often, when seized with a cough, fell down as though struck by lightning. Another patient, also, who was subject to a cough which had no special character, suddenly fell down when the cough came on. In neither of these cases were there any signs of syncope or epilepsy. M. Charcot was inclined to regard such cases as a kind of laryngeal vertigo, analogous to Menière's vertigo, which has its starting-point in the ear. In this malady, according to Menière, there is first a sensation of a "strident noise," and then the patient falls with his face to the ground. M. Laborde stated that in dogs in which pleuritic effusions have been artificially induced, true epileptiform attacks may be brought on by injections into the pleura.—*Med. Times and Gaz.*, Dec. 9, 1876.

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Remarkable Case of Injury to the Head.—Dr. Barlach relates the case of a boy, twelve years old, over whose head the wheel of a wagon had passed, but who then got up and walked beside the horses. He did not suffer much pain, but felt faint, and as if something were projecting from the head. A cloth was wrapped round his head, and he was conveyed in a wagon to Dr. Barlach's residence, who saw him about an hour and a half after the accident. He was quite sensible, and had his face and head covered with dried blood. The head having been cleansed, under chloroform, it was found that the right half of the frontal bone had become separated from all its connections, being held on to the left half only by the clotted blood and hair and some shreds of periosteum. The portion of bone measured nearly nine centimetres and a half. The dura mater was uninjured, but covered with blood, small stones, straw, etc. It is to be observed that during the inhalation of chloroform the pulsations of the brain became remarkably stronger, and all the vessels that were visible assumed a very dark appearance. The scalp was brought over the exposed parts, and the ensuing suppuration treated by drainage. Febrile action continued during the first two weeks, after which all did well, the lad having quite recovered by the end of January, the accident occurring in October. His intellectual faculties have undergone no alteration, and he suffers little inconvenience from the defect in his skull. —*Med. Times and Gazette*, Nov. 18, 1876, from *Allg. Wien. Med. Zeitung*, Sept. 26.

—

Emphysema of the Skin during Parturition.—Dr. P. Alekschieff mentions in the *Russisch Med. Rundschau*, Bd. 2, 1876, a rare complication of parturition which he observed at the obstetrical clinic of Moscow in a primipara, twenty-four years of age. During the application of forceps, rendered necessary by a contracted pelvis, a tumefaction of the skin of the neck was observed above the right clavicle, and this tumefaction increased largely during the uterine contractions. There was observed an intumescence of the face, and especially of the palpebræ, the neck, and the upper portion of the thorax. This swelling constantly increased, and a manifest crepitation could be felt with the finger. Nothing particular could be perceived in the respiratory organs, except a certain weakness of the respiration of the right side. A live child was delivered with the forceps, and the emphysema disappeared in twelve days without any treatment. This case was due to the passage of air to the skin through lacerations of the pulmonary tissue, the result of intense muscular contractions.—*Med. Record*, Dec. 16, 1876, from *Lo Sperimentale*, August, 1876.

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Hydrophobia communicated by a Non-Rabid Dog.—Dr. MORITZ related to the St. Petersburg Medical Society the case of a boy who died with well-marked symptoms of hydrophobia six weeks after being bitten by a dog, the dog up to the time of the boy's death never having exhibited any sign of rabies. A similar case was communicated to him by a colleague, of a boy who also died hydrophobic after being bitten by a cat, the cat remaining to all appearances well. Dr. Severin had also met with a case of a child dying who had been bitten by a dog that continued well. He had inoculated rabbits with saliva, blood, and pus taken from this child, without producing any results.—*Med. Times and Gaz.*, Dec. 2, from *St. Petersburg Med. Woch.*, Nov. 11, 1876.

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Colour-Blindness among Railroad Employés.—With reference to colour-blindness, or the lack of power to distinguish colours, it is stated that very few of the persons so affected are conscious of the defect in their vision. Many railroad accidents are caused by the colour-blindness of railroad employés, and the Swedish Railway Direction has recently ordered an examination to be made by oculists of all the men in its employ, so as to guard against all danger. Professor Holmgren, who has just examined the employés of the Upsala-Gefle Railway, found that, out of 266 persons examined, 18 were colour-blind, and so utterly unfitted for the railway service.—*Public Ledger.*

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Typhoid Fever in Paris.—Enteric fever has prevailed in Paris very considerably during the third quarter of the last year, the number of cases being double that of the mean rate of the corresponding period during the preceding four years, as shown by the report of M. Besnier. There was not only an increase in the number of cases, but also in their fatality. On the 11th of November, the mortality in Paris from typhoid fever was 171, against 59 in the preceding week.

—

Death from Self-administration of Chloroform.—Dr. GUSTAV JUDELL, privat-docent and chemical assistant in Professor Leube's clinic at Erlangen, was on October 26 found dead in his bed. He had been accustomed to take chloroform at night as a remedy for sleeplessness, by which he was much troubled; and a bottle containing the anæsthetic was found near him. It appears that vomiting was excited by the chloroform, but that he was too deeply narcotized to eject the contents of the stomach, so that portions of the food remained in the œsophagus, and caused death by suffocation.—*Clinic*, Dec. 16, 1876, from *Brit. Med. Journal.*

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Iodide of Starch as an Antidote.—Iodide of starch has been employed in paste as a dressing in foul and syphilitic sores, but has been little used internally. Dr. Bellini, Professor of Toxicology at the Royal Institute of Florence, recommends it as a valuable antidote in some cases of poisoning, especially by alkaline and earthy sulphides, caustic alkalies, and ammonia, and the vegetable alkaloids for which iodized solutions are generally given. In poisoning by alkaline or earthy sulphides he believes it preferable to all other antidotes; in poisoning by caustic alkalies it is applicable when acid drinks are not at hand. Where iodized solutions of iodide of potassium are usually employed for poisoning by vegetable alkaloids, the iodide of starch should be used instead, as far less irritating. It may also be given in some cases of chronic lead or mercurial poisoning, and particularly to children in the form of syrup.—*Lancet*, Dec. 9, 1876.

Method of preventing Cloudiness on Exploring Mirrors.—M. SANUNDÈS, a medical student, communicates to *L' Union Médicale* (Sept. 23) a new process of preventing the laryngeal mirror from becoming obscure. This consists of passing lightly over the mirror a cloth steeped in glycerine. The watery vapour contained in the expired air is dissolved completely in the glycerine and the cloud does not form. He proposes the extension of all glass and optical instruments liable to become obscured by cloudiness.—*Med. Record*, Dec. 16, 1876.

Tuberculous Beef.—Our contemporary *The Field* has recently published some rather remarkable articles on cattle diseases. The last disease discussed is consumption, or, as it is more commonly called by cattle-breeders, "grapes." The frequency of this disease is deplored, and amongst the conclusions arrived at are, that it is hereditary, that it is capable of propagation by inoculation, but that it is by no means certain that it can be transferred by eating phthisis-tainted meat. For some little time we have been collecting information on this important subject, for it is a matter of fact that hardly 1 per cent. of the animals afflicted with tubercle are consumed as food. There is, in mild cases at least, no deception practised in the matter. Indeed, were tuberculous beef excluded from the market, 50 per cent. of the animals slaughtered would have to be condemned. This estimate is no exaggerated one; but it must be borne in mind that we are speaking of tubercle in any stage. Tuberculous disease is not confined to poor, worn-out, or half-starved cattle; it is remarkable that highly-bred fat cattle are peculiarly liable to it. In fact, if the fat beasts at one of our great shows were examined, the lungs of a great proportion of them would be found touched. It is in no alarmist or sensational spirit we call attention to this important question. If it can be proved that meat from an affected beast can convey the infection, then, at any cost, such meat should be condemned. Should such be the case, the advice most honestly and *bona fide* given by our excellent contemporary will not be reassuring. It is advised that an affected beast should at once be fatted and killed, as no remedy can be relied upon. At present, we will not controvert this advice, but only urge a thorough scientific inquiry into the whole question of cattle diseases and their probable effect on public health. The Public Health Act does not attempt to define unsound, or unwholesome, or unfit-for-the-food of-man meat. All is left to the discretion of the medical officer of health or inspector of nuisances. Indeed, no other persons can legally seize or order such meat to be seized and taken for magisterial decision. We swallow so many camels that it is sheer nonsense to strain at gnats; nevertheless, it ought long ago to have been scientifically and positively ascertained whether meat from beasts which are affected with lung-disease, tubercle, or puerperal fever could safely be eaten by human beings. Another and not minor branch of the same subject should also be settled, and that is as to the effect on the consumers of the parasitically diseased meat, of which such huge quantities are consumed daily. Any skeptic as to this last fact will easily be satisfied as to its truth if he will only inspect the first lot of sheep's plucks he may come across in his morning's walk.—*The Sanitary Record*, Oct. 21, 1876.

Cultivation of Ipecacuanha in India.—Experiment in growing ipecacuanha in India is said to have been very successful. A quantity of the dried root grown in Bengal was pronounced, after extensive trial at the hospitals in the treatment of dysentery, to be as effectual as the best South American drug. Quantities of ipecacuanha have now been sent to the Neilgherries, to Ceylon, and to British Burmah for trial, and those qualified to express an opinion are hopeful of success.—*Lancet*, Dec. 2, 1876.

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CLINICAL LECTURES.

Clinical Lecture on the Treatment of Wounds. Delivered at the Queen's Hospital, Birmingham, by SAMPSON GAMGEE, F.R.S. Edin., Surgeon to the Hospital.

GENTLEMEN: Wounds of all kinds must, while you are surgeons, be the objects of your care. The one great question for you to solve will be, how least painfully, how the most speedily and most safely, you can assist or promote the natural process of healing.

Teachers, in text-books and hospital wards, differ very widely on the theory and practice of this fundamental part of surgery. I shall not attempt to enumerate their differences, much less either to confute or reconcile them. My present aim is to place before you the evidence of typical cases, in the support of what I believe to be the first and essential principles which should govern the practice of the surgeons in treating wounds.

I invite your attention to this little old gentleman, who has kindly attended here this morning for your instruction. He consulted me about two months ago for a cystic tumour, about as large as a hen's egg, in the right temporal region. The skin was very red, tense, and painful, and the hat, though a very soft one, was worn with much difficulty. After transfixing the growth vertically through the base, and peeling out the two halves of

Published monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

☞*In no case is this periodical sent unless the subscription is paid in advance.*

the cyst, with its bread-sauce-like contents, I dried the interior of the wound with a fine sponge. The edges were then very accurately approximated, and kept so with a few strips of lint soaked in styptic colloid. A few turns of bandage completed the dressing. When I removed it, at the end of five days, there was not a drop of discharge, adhesion was perfect, and afforded a simple but complete illustration of the surgeon's first intention in treating wounds—to secure direct union. All that is visible of the cicatrix is a very fine, pinkish line, extending upwards about two inches from the right ear.

Please to note—firstly, that the wound was thoroughly dried with a fine sponge; secondly, styptic colloid was used to keep the edges in contact; thirdly, the parts were not disturbed until the fifth day, when union was complete and solid.

Drenching wounds with water during an operation, and washing them with it afterwards, are mistakes. Water favours decomposition, which is the enemy of healing action.

The styptic colloid, used to keep the edges of the wound together, is the admirable preparation introduced in 1867 by my friend Dr. B. W. Richardson.[1] In removing the styptic colloid dressing common water should be scrupulously avoided, and a mixture of alcohol and ether employed, or equal parts of absolute alcohol and distilled water, warmed to a little above the heat of the body.

It has been noted that the dressing was not touched for five days after the operation. Once divided parts—be they hard or soft, bones or muscles, skin or nerves—are adjusted with a view to union, the less they are disturbed the better.

A case illustrating the same principles, though on a somewhat larger scale, is that of C. H——, aged forty-three, who was lately in Ward 5, whose right breast I removed on the 20th May, with a small hard gland from the corresponding axilla. Of the operation it only need be said that, according to my usual practice, I cut down upon the sternal origin of the great pectoral and dissected it clean, so as to make sure of thorough removal of the diseased mass. I am convinced that many so-called rapid recurrences of cancer are only growths of pieces left behind, and that *thoroughness* is the very essence of success in extirpation of malignant growths. After removal of the breast, the edges of the wound were neatly brought together by numerous points of silver suture, and dressed with a layer of fine cotton-wool and over it picked oakum. An evenly compressing bandage was then applied round the chest, and made to include the arm and hand in the flexed position so as to fix them immovably to the side. The first night the temperature rose to 101.3°, but it never rose afterwards above 100°.

The wound was first dressed at the end of the fifth day after the operation. A great part of it being healed by the first intention, a large number of the sutures were removed, and strips of adhesive plaster applied, so as to keep the edges in apposition; a pledget of oakum with a compressing bandage completed the dressing. On June 1st the remaining sutures were removed. The wound was then nearly all healed, and the same dressing applied. On June 3d (fourteenth day after operation) the entry on the card is "Patient dressed (as before), and sent home well."

The points in this case to which I wish to direct your attention are—(*a*) the numerous sutures; (*b*) the cotton-wool and picked oakum dressing; (*c*) the compressing bandage; (*d*) the rare dressing.

Metallic sutures so very rarely cause any irritation, that they may be inserted very near each other with impunity. Sutures far apart, with gaping intervals, are comparatively useless. If the cut surfaces are to adhere, they must be brought into contact and kept there, and for this purpose metallic sutures half an inch apart, or even less, are most efficacious. I often apply intervening strips of lint soaked in styptic colloid, but in this case only placed over the wound a layer of fine cotton-wool, and a pledget of picked oakum. The best cotton-wool for surgical dressings is that sold for jewellers in thin sheets, about eighteen inches by twelve, with alternate layers of tissue-paper. You will often see claims of priority for cotton-wool dressing. I do not pretend to say who first introduced it, but the credit of generalising its application in the treatment of a great variety of surgical injuries chiefly belongs to Burggraeve, of Ghent.[1]

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[1] Styptic colloid, as prepared after the instructions of Dr. Richardson, F.R.S., by Messrs. Robbins & Co., of Oxford Street, is produced by saturating ether entirely with tannin and a colloidal substance, xyloidine, or gun cotton, a little tincture of benzoin being finally admixed. (Vide D. B. W. Richardson in Medical Times and Gazette, 1867, vol. i. p. 383 et seq., "On a new Styptic and Adhesive Fluid—Styptic Colloid; and on healing by the First Intention." Also, by the same author, "On the Science and Art of Healing Wounds," in Transactions of St. Andrew's Medical Graduates' Association for 1871, London, 1872, p. 37 et seq., and MEDICAL NEWS, June, 1867, p. 81.)

It has been recorded that the breast case was only dressed three times, in the fortnight which elapsed between the operation and the patient's discharge, in accordance with the principle of infrequent dressing, of the minimum of disturbance to insure the maximum of rest, dwelt upon in the preceding case, and equally borne out by those to be presently brought to your notice. To the same end the smoothly and lighly compressing bandage round the chest very powerfully contributed. Of all surgical agencies none so beneficent as compression, none requiring more delicate manipulation, none so inadequately appreciated. Under a smooth and uniformly, while lightly compressing bandage, extravasations of blood are absorbed, the healing action is promoted, and a soothing influence is exercised. There must be no constriction —only equable adaptation of surface to surface with the light pressure which always comforts. There must be no squeezing like that of an old college friend's hand when seen after long absence; such pressure as that, if continued, is intolerable constriction. The soothing surgical pressure is like that which you interchange with the hand of a lady, the pleasure of whose meeting is tempered by the respectful regard which she inspires. Your hand adapts itself to hers, and gently presses it wherever it can touch it, but nowhere squeezes it for fear of offending. Such pressure as that, when employed by the surgeon in the treatment of injuries, always soothes and heals.

To apply a nicely compressing bandage well, you must practise hundreds and hundreds of times, bearing in mind that in surgical, as in all art, the greatest results are often obtainable from the simplest means, provided they be employed with the skill which can only result from the most patient assiduity.

These principles are illustrated by the two patients who have undergone amputations, and who are now before you.

I amputated the middle finger of this man's right hand in the course of my clinical lecture last week. As the result of old injury, the finger was bent and stiff, so as to be in the way. I therefore removed it at the metacarpo-phalangeal articulation, being careful not to wound the palm, and including in the elliptical incision so much of the covering of the phalanx as to admit of easy closure of the wound over the big knuckle. The edges were united by three points of silver suture, a fine drainage-tube placed in the lower angle of the wound, which was covered with a pledget of picked oakum; a moist pasteboard splint was now bandaged to the palmer aspect of the limb from the tips of the fingers to the elbow, and the forearm suspended in a sling.

This other patient, aged sixteen, was admitted to Ward 3, the 18th May ult., with his forearm crushed by machinery to within two inches of the elbow. As the bones were not split into the joint, I amputated just below it, utilizing some of the least damaged skin to cover it. Where the skin was quite sound the edges were brought together with two points of suture, elsewhere the parts were approximated with strips of lint soaked in styptic colloid, a drainage-tube being left in the lower part of the wound. The stump was covered with a layer of cotton-wool and oakum, and rectangular pasteboard splints were applied with gentle pressure to insure perfect immobility and prevent swelling. When the apparatus was opened four days afterwards, there was very slight sloughing of the margin of one flap, but the stump was of good colour and healthy temperature, without tension. The same dry dressing with pressure was applied, and the lad was discharged on the 17th of June, a month within a day from his admission, the stump then quite healed, having been dressed altogether seven times after the amputation.

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[1] Chirurgie Simplifiée. Nouveau Système de Pansements Inamovibles. Par le Dr. Burggraeve (avec planches). Bruxelles, 1853. Also, by the same author, Le Génie de la Chirurgie. Gand, 1853, p. 25 et seq.

A parallel case is that of James B——, aged six, discharged the other day from Ward 6. The soft parts of his left lower limb had been extensively crushed by a wagon, and an attempt had been made to save the limb. Sloughing and profuse suppuration had been followed by such exhaustion that the lad might fairly be said to be moribund when I amputated the thigh in the upper third on the 22d of April. I dressed with cotton-wool, oakum, pasteboard splints, and nicely compressing bandages, and the lad was discharged with a sound stump and in good health on the 15th of June. In the forty-seven days which elapsed from the operation to his leaving the hospital the dressing was only renewed six times.

Not to go over the ground already trodden in commenting on the other cases, I shall only remark on the splints and the drainage-tubes employed in these amputations.

Coaptation of divided surfaces once effected, absolute rest is the first essential to the healing process. That rest is best secured, in the case of amputations, by moulding to the stump well-softened pasteboard splints, and fixing them with evenly compressing bandages. As in the case of fractures, the joint above the injury should be included in the splints, and great contributory benefit may be derived from the nice adaptation of sand-bags.

Of Chassaignac's drainage-tubes in the treatment of wounds it is impossible to speak too highly; but useful as they are after amputations, removal of tumours, and such-like operations, it is in such cases as this breast that their advantages are perhaps most conspicuous.

When this woman was before you last week, her pale, drawn face betokened suffering and exhaustion; the big, pendulous, and exquisitely tender left breast discharged matter through half a dozen openings, the result of post-partum mammary abscesses and linseed poultices. I passed a long probe from the lower aperture on the outer side, under the mammary gland, obliquely upwards and inwards, out at the uppermost aperture near the sternum. A ligature secured to the eye of the probe enabled me to carry a good-sized drainage-tube along its track, and I left it there with both ends depending, covering the breast with a good pledget of dry oakum, and suspending and compressing it with an evenly compressing bandage. The poor woman was easy at once, her appetite improved, and she slept well. When the dressing was removed, after a lapse of four days, the breast was soft and much diminished in size; the openings other than those traversed by the drainage-tube were healing rapidly, and the woman is now cheerful and rapidly convalescent.

Here is an equally successful case of a different kind, yet illustrating substantially the same general principles which should guide you in the treatment of all wounds. This youth is the son of one of our principal ivory and bone turners, who, while practising the other day with a fine circular saw, nearly cut off the soft pad at the end of the right thumb. He did not consult me until the third day, when the flap was swollen, and the wound dirty, the whole thumb throbbing and being very painful. On compressing the radial joint above the wrist, the throbbing and pain ceased, and I taught my patient how to obtain the relief by effecting the compression himself with the left thumb. I then brought the edges of the wound together with narrow strips of emplastrum elemi, leaving slight intervals for the escape of matter, covered the end of the thumb with a little fine-picked oakum, bandaged it so as to effect gentle uniform compression, and supported the hand at an acute angle with the arm, by means of a sling supporting the forearm and enclosing the elbow, as every sling, to be efficient, should do. Relief was immediate; the dressing was not touched for four days, and only twice afterwards, at intervals of three days. You see the thumb very nearly a match for its fellow, and a linear cicatrix is all that is left of the ugly wound.

This case illustrates, like the previous ones, the advantages of direct compression, with dry and rare dressings, in the treatment of wounds, and it further exemplifies the benefits to be derived from digital compression in the treatment of inflammation of the limbs.[1]

In proof of the statement that the same principles of treatment are applicable, whether the wounded parts be soft or hard, skin, bones, or muscles, or all combined, you have two very striking cases. This carter was brought into the accident ward with the scalp torn from the greater part of the right side of the head, and with two compound and depressed fractures in the parietal and frontal bones respectively. The large flap was cleansed, replaced, and united by eight points of suture, picked oakum and light bandage applied, and an ice-bag over all. The greater part of the wound united by the first intention. The cicatrix is now quite solid, and the man is doing his usual laborious work without ache or pain.

The last case which I shall now bring before you is that of a porter on the Midland Railway, who was brought to the hospital, a distance of fourteen miles, with the left femur literally smashed just above the knee-joint, a fully-laden coal-truck having gone over the limb. The soft parts were extensively torn, but both tibials pulsated, and I felt justified in the attempt to save the limb. Reduction effected and the edges of the wound approximated, a large drainage-tube was passed into it, and a pledget of lint, soaked in styptic colloid, placed over it. The limb was now accurately encased in a pasteboard apparatus from the crest of the ilium to the toes. The apparatus was not opened for ten days, and once a week afterwards. The man barely limps in walking, and is now doing duty as a signal-man at Selby-cut. One and all these cases illustrate my favourite maxim, that REST, POSITION, and PRESSURE are the trinity of healing surgical graces.—*Lancet*, Dec. 23, 1876.

HOSPITAL NOTES AND GLEANINGS.

Large Retro-uterine Hæmatocele; Incision; Recovery.—A married woman, aged twenty-four, was admitted into the Queen's Hospital, Birmingham, under the care of Mr. JOHN CLAY, on August 29, 1876. She had three children, the youngest of which was twenty months old and was suckled until a month before admission. Her labours had always been good and without complications. Menstruation occurred at the end of a month after the last confinement, and appeared regularly afterwards. During her last menstrual period, about a month since, while engaged in washing the yard, she was suddenly attacked with a violent pain in the back, and in the hypogastric and right iliac regions, where the pain was most acute. She had frequent attacks of pain after this of a spasmodic character which were generally more severe during the night, and were accompanied with distressing dysuria. There was a free menstrual discharge during the whole of the month previous to admission. A fortnight before she had rigors, accompanied with nausea and vomiting, and was compelled to take to her bed. She then discovered a painful swelling on the right iliac region. This, according to her belief, gradually increased in size.

On admission she was anæmic and emaciated; the recumbent posture only possible; legs not drawn up. Abdomen tender on pressure. Pains in the regions previously mentioned. In the right iliac region there was a firm swelling of the size of a large orange. The upper border of this swelling was irregular, and could be traced in an oblique direction, running from the right iliac crest to the middle of the left groin. Below this line the abdomen was dull on percussion, and the swelling was nodulated, and the boundary-line of the latter was about an inch and a half from the umbilicus. There was a free vaginal discharge of a dark rusty colour. Per vaginam a hard rounded mass was felt completely filling Douglas's space, and pushing the uterus downwards and forwards, simulating in feel and size a gravid uterus of the fourth month in a retroverted condition. The sound was introduced into the uterus without difficulty. The uterus measured three inches, and was in its normal position. Per rectum the mass could be distinctly felt, and the bowel was pushed down in folds. Tenesmus and dysuria very distressing. Pulse 100; temperature 101°. Salines and opiates ordered.

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[1] Observations on the Treatment of Inflammation by Digital Compression, by Dr. Tito Vanzetti. On Treatment of Fractures of the Limbs, by Sampson Gamgee; London, Churchill, 1871; p. 168 et seq.

Sept. 5. There is an increase in the size of the swelling, and it feels firmer. The upper border is now felt to be on a level with the umbilicus. Abdomen tender on pressure. Pulse 98; temperature 101.4°. Quinine mixture prescribed; opiates continued.

9*th.* The abdomen is extremely tender and tympanitic. Peritonitis is obvious. The aspirator was used to the vaginal swelling, but only a little thick blood followed. Pulse 140; temperature 102.6°.

10*th.* Abdominal pain and tenderness increased. Knees drawn up; countenance anxious. Pulse 140; temperature 102°. Consultation convened, at which Drs. Heslop and Mackay and Mr. Clay attended, in reference firstly to the probability of the extravasation being due to tubal fœtation; and, secondly, as to the advisability of evacuating the extravasated blood per vaginam by a free incision into the tumour. The first question, after mature consideration, was not considered very probable, and it was deemed advisable to defer the latter.

11*th.* 10 A. M.: Patient states that she feels better. Abdomen, however, more tympanitic; no sickness. Pulse 132; temperature 103°. To take of acetate of morphia a quarter of a grain every four hours. Compresses wrung out in iced-water to be applied to the abdomen. Is decided to have a consultation in the evening. 7.30 P. M.: Patient much worse in every respect, vomiting and hiccough; abdomen enormously distended. Pulse 142; temperature 103°. It was determined to incise the tumour without further delay. Mr. Clay, with a guarded bistoury, made an incision of about one inch and three-quarters in length into the centre of the vaginal swelling. The finger was passed through this opening, and the clot broken up by this means; about two pounds of hard offensive clot and coloured liquid were removed. The cavity was carefully syringed with diluted Condy's fluid. The same quantity of morphia was prescribed with a small quantity of brandy every two hours. After the incision and syringing the boundary line of the solid mass was felt to be about two inches nearer the pubis.

12*th.* Patient has had two severe attacks of abdominal pain. After the operation a discharge of bright red blood continued to escape from the vagina, probably from a vessel in the incision, which was arrested by a plug introduced by Mr. Allen at 3 A. M. Urine and flatus passed in large quantity during the night. Tampon removed and cavity syringed out with diluted Condy. Temperature 103°; pulse 136. Morphia continued. Insufflation of the cavity ordered every three hours with salicylic acid.

13*th.* Bowels moved three times during the night; addomen very much diminished in size. Pulse 120; temperature 102°.

On the 14*th* a large quantity of dark offensive clots were removed by syringing the cavity with Condy's fluid, from which she felt much relief. The pulse and temperature daily declined until they became normal. No trace of fœtal development was discovered, although careful examination was daily made of the débris brought away by syringing. Salicylic acid was administered for several days in ten-grain doses with the best results. Quinine was afterwards substituted. By the end of the month she was quite convalescent, all traces of the abdominal hardness having disappeared, and the incision quite healed. She remained, however, anæmic, but with the use of tonic medicines and a generous diet she made a most rapid and permanent recovery. Menstruation had not occurred when she left the hospital for the Convalescent Institution.

In commenting on this case, Mr. Clay remarked that it was one of unusual interest, not alone for the special clinical features it presented, but as illustrating the mode of treatment to be adopted where large extravasations of blood into the cavity of the abdomen had taken place. Of late years the current of opinion has gone somewhat in the direction of leaving these large sanguineous extravasations to become removed by absorption aided by therapeutical measures. There are, of course, those who advocate surgical interference, and the favourable result of this case lends a powerful support to the adoption of this method of treatment in certain cases. There can scarcely be a doubt that in the progress of this case fresh extravasations occurred, which materially increased the size of the tumour. It might have been thought that the temporary increase of size was due to a distended bladder, but it is scarcely necessary to observe that this source of error was carefully guarded against. The opening of the tumour at too early a period of its development would probably have been a fatal mistake. The prudence of the delay sanctioned by the gentlemen engaged in the consultation in the first instance was shown by the fact that the peritonitis set up had completely encapsulated the clot, and thereby facilitated dealing with it after the tumour had been incised. There was no softening of the clot. The fragments which came away were firm, offensive, and dark-coloured, and to have delayed the incision would have insured the death of the patient. Another fact of importance is that the convalescence is considerably shortened. The employment of salicylic acid as a local antiseptic was only partially successful, in consequence of the large amount of blood to be acted upon, but its internal administration was marked with the best effects. The rapid diminution of temperature, pulse, and meteorism in the first twenty-four hours after the incision are worthy of prominent notice. The lesson which this and other similar cases had taught him was not to expect large extravasations to be removed by absorption. That such cases should not be interfered with surgically at too early a period is a safe proceeding, but that they should be watched, and, whether softening takes place or not, if the temperature and the pulse show extensive abdominal complications to be taking place, then at once to make an opening for the coagulated blood. The tolerance of such large continued doses of morphia is also worthy of note. The position and feel of the tumour on the right side of the abdomen lent a powerful impulse to the belief at one time that the origin of the extravasation was due to a rupture of a tubal pregnancy, but no traces of a fœtal development could be found. There was besides no history of shock, which generally occurs in such case, and this fact, together with the absence of certain uterine symptoms, was rightly held to negative the supposition.—*Lancet*, Dec. 2, 1876.

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Rheumatic Fever treated by Salicylic Acid; Symptoms of Poisoning produced by the Acid.—The following two cases of rheumatic fever treated at the Radcliffe Infirmary, Oxford, with full doses of salicylic acid, are interesting, as showing a peculiar train of nervous symptoms which seem to have followed, and been caused directly by, the administration of the medicine. In both, the immediate effect of the acid on the rheumatic symptoms was remarkable—a rapid falling of the temperature and pulse-frequency, a speedy subsidence of pain and swelling of the joints, a cleaning of the foul tongue, and arrest of the sweating being observed. But in both alike, together with the satisfactory abatement of these symptoms, there came on a set of other symptoms, which may thus be summarized: Humming and buzzing in the ears, with gradually increasing deafness; a peculiarly loud, deep, and sighing respiration; a strange restlessness, gradually increasing to delirium, not unlike that of delirium tremens, with involuntary evacuation of urine and feces in the worst of the two cases; a slow and labouring pulse; an olive-green colour of the urine. All these symptoms declared themselves at the same time that a low temperature, a slow pulse, and an absence of all rheumatic appearances, showed that the disease itself was in abeyance. No sooner was the medicine withheld than the strange symptoms ceased, and the rheumatism returned. In the case related at length, the nervous symptoms were so alarming that Dr. TUCKWELL was afraid to return to the acid in treating the relapses, but blistered the joints after Dr. Herman Davies' plan, a treatment which he had followed out for several years. To compare the blistering with the salicylic acid, both alike seem to act quickly on the painful swellings of the joints; but, whereas the former does nothing more than this, and the rheumatic state continues its course unchecked, the latter seems to have the additional power of controlling the rheumatism itself, of lowering and keeping down the temperature and pulse, and relieving the sweating. At the same time, when given in doses large enough to effect this, the acid may develop certain unpleasant symptoms of its own, which in one of the cases to be related were rather alarming.

Case 1.—H. L——, aged eighteen, was admitted 29th Sept. 1876. He had had rheumatic fever when a child, but had continued in good health and at work till seven days ago, when he shivered, and was attacked with pain in the back and with painful swelling of the knees. On admission he was profusely sweating, with rheumatic odour. Both knees, both ankles and wrists, were acutely inflamed, swollen, red, and very painful; tongue thickly coated. Morning temperature 100.6°; pulse 108. Evening temperature, 101.6°. A blowing systolic murmur was heard at the apex, and a shorter systolic murmur at the base of the heart. Ordered to be bedded in blankets, to have no application of any kind to the swollen joints; milk diet; and to have a scruple of salicylic acid dissolved in three drachms of the solution of citrate of ammonia[1] every three hours, through the day and night.

Sept. 21. The pain had begun to yield at midnight, after four doses of the mixture. All pain and swelling of the joints were gone, and there remained only a little stiffness in the left knee; tongue cleaning. Morning temperature 101°; evening 101.6°; pulse 92. He complained much of thirst, and of buzzing in the ears, as if a hive of bees were over his head. The respirations were regular and slow, sixteen in the minute, but peculiarly deep-drawn and sighing, so that he could be heard breathing at some distance from the bed. Ordered to continue the mixture every three hours.

22d. All rheumatic pain, swelling, and stiffness were gone, and the sweating was much less; tongue clean. Morning temperature 100°; evening 100°; pulse 84. The loud breathing was even more marked. He had passed a very restless night, and was restless at the visit, complaining of the buzzing and of feeling light-headed. Heart-sounds unchanged. Urine of a marked olive-green tint; acid; no albumen. To continue the mixture every four hours.

23d. He was quite free from all rheumatic symptoms, but the same noisy breathing and restlessness continued. A patch of herpes had appeared on the lip. Morning temperature 99°; evening 99.6°; pulse 92. Urine olive-green; the colour not changing on the addition of nitric acid; no albumen.

24th. The same nervous symptoms, with the addition of marked deafness, were present. Morning temperature 97.6°; evening 97.8°; pulse 84. To continue half doses of the mixture, ten grains of the acid, every four hours.

25th. The breathing was so loud that it could be heard at the other end of the ward. He had passed a sleepless night. Morning temperature 98°, evening 99°; pulse 76. Heart-sounds unchanged. To continue ten grains every six hours.

26th. He had been sleepless and delirious throughout the night, trying to get out of bed. He answered questions properly, but then rambled off to some other subject. Breathing the same. Morning temperature 99.4°, evening 99.2°; pulse 62. To take 10 grains three times a day.

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[1] On the solubility of salicylic acid in a solution of ammonium citrate, see the Pharmaceutical Journal of July 15th, 1876.

27*th*. He passed a very delirious night, and had the manner of a person with delirium tremens. He had passed his feces and urine unconsciously. Breathing the same. No rheumatic symptoms. Morning temperature 99°, evening 100°; pulse 70, labouring. Urine olive-green, no albumen. To stop the medicine, and continue milk diet.

28*th*. He had continued in the same state till three o'clock this morning, when he fell asleep, and was still sleeping heavily at the time of the visit. Morning temperature 99.2°, evening 99.8°.

29*th*. He had slept the greater part of yesterday and all through the night, and awoke this morning quite quiet and sensible. His evacuations have since then been passed naturally. His breathing was quiet and natural. Morning temperature 99.4°, evening 99.8°; pulse 52, very labouring, and a little irregular. He was very prostrate, and could only speak in a whisper. Heart-sounds unchanged. Urine very faintly green in colour, neutral, no albumen.

30*th*. He was quiet and rational, and breathing naturally, but all the old rheumatic symptoms had returned. He was sweating profusely. The right knee, ankle, and left wrist were swollen and painful. Morning temperature 100°, evening 102.2°. Joints to be blistered. Effervescing citrate of potash mixture to be taken every six hours.

Oct. 1. The joints were much relieved by the blisters. No nervous symptoms. Morning temperature 100.6°, evening 101.2°; pulse 60. Urine natural in colour, 1028, no albumen. Heart-sounds unchanged.

3*d*. Another relapse of rheumatic pain and swelling in the left knee and left ankle, with profuse sweating. No nervous symptoms. Morning temperature 102.4°, evening 103°; pulse 72. Joints to be blistered.

From this time there was a gradual fall in the temperature and return to convalescence, no fresh nervous symptom of any kind having appeared from the time that the salicylic acid was discontinued, although the temperature rose higher and the affection of the joints was severer in the relapses than in the original outbreak.

In Case 2—that of a man aged twenty—the order of treatment was reversed, blisters being first applied, and afterwards, as the fever did not yield, salicylic acid being given in doses of a scruple every three hours. In twenty-four hours from the time that the first dose was taken, all pain and swelling were gone, the temperature and pulse had fallen, and the tongue was cleaning; but there followed just the same nervous symptoms as in the former case—deafness and buzzing in the ears, deep-drawn noisy breathing, restlessness, and at last delirium, with wakefulness and a desire to get out of bed. All these symptoms, which were not so severe as in the former case, ceased quickly when the acid was withdrawn, and did not return, although there were two slight relapses of the rheumatic fever, which were treated with the perchloride of iron.—*Lancet*, Nov. 11, 1876.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Fractures at the Pennsylvania Hospital.—Dr. JOHN B. ROBERTS, Resident Surgeon at the Hospital, gives (*Archives of Clinical Surgery*, Dec. 1876) the following account of the method of treating fractures employed at this institution:—

Fractures of the lower end of the radius, whether Colles', above the articulation, or Barton's, extending into the joint, are almost invariably adjusted by forcible extension, and then placed in a Bond's splint, with appropriate compresses to correct deformity. Bond's splint, as you know, consists of a box-like splint, in which the pronated forearm is laid, while the hand is deflected to the ulnar side, and the palm closed over a cylindrical block at the end. By this means the tendency to dragging up of the lower fragment is overcome, and the fingers are allowed considerable motion during the progress of the treatment.

When the humerus is broken, through or just above the condyles, an anterior right-angled splint is generally employed, but when the fracture is situated in the shaft, an internal angular splint, with possibly an external pasteboard one, is applied. If the seat of fracture, however, is near the anatomical neck, it is usual to use the thorax as a splint, and merely bind the arm firmly against the chest; should the upper fragment tend to fall into the axilla, it is kept in proper position by a pad placed in that locality.

The treatment that seems to give best results in fracture of the clavicle is the horizontal position in bed, with the head thrown a little forward to relax the sterno-mastoid muscle. When this line of treatment cannot be followed, the injury is dressed with a roller-bandage or adhesive strips, so arranged as to meet the indications.

Taking up fractures of the lower extremity, I speak of fracture of the fibula. This comparatively unimportant injury is placed in a fracture-box until swelling subsides, and then a fixed dressing of silicate of soda, or glue and oxide of zinc is adjusted to the limb.

Fractures of the tibia, or tibia and fibula, are placed immediately in the old-fashioned fracture-box with foot-board and hinged sides, which, in many instances, is then suspended, in order that the patient may move about in bed without disarranging the broken bones. Compound fractures, with abundant discharge, are kept covered with bran. In two such cases, recently admitted, there was so much overlapping and displacement of the fragments that Dr. Morton resected the ends, and, in one case, wired the bones together.

Although the fracture-box is generally employed, its use is not absolute. If the bones be broken at the ankle-joint, with lateral displacement, Dupuytren's splint and pad for fracture of the fibula are used. In a recent instance, where the line of fracture split off the external portion of the tibia, without involving the internal malleolus, and the fibula also was broken, there was great displacement backwards and outwards, which necessitated tenotomy of the tendon of Achilles and the application of Dupuytren's splint on the inner side of the leg.

Fracture of the patella has usually been treated by flexing the whole limb on the pelvis, and drawing down the upper fragment by adhesive strips and bandages. Recently, however, Dr. Morton has tried Malgaigne's hooks without producing any inflammatory trouble, and has obtained far more perfect apposition under their application.

Many cases of fracture of the femur are admitted, and are treated generally by extension, though one of the surgeons prefers Smith's anterior wire splint. The extension apparatus is applied by means of longitudinal and transverse strips of adhesive plaster, to which is attached an iron crib, or framework, containing any number of one pound weights. In some cases, instead of the plaster, a more expensive arrangement of leather straps and buckles is applied in a similar manner, and the weights attached to the foot-piece. The injured limb is then steadied by sand-bags or Levis's weighted splints, which consist of long narrow boxes, containing a row of bricks. Fractures through the neck of the femur, owing to the difficulty of making an absolute diagnosis of extra or intra-capsular lesion, are treated by extension for several weeks, until it is determined whether or not union is about to occur. In a case treated not long ago, the diagnosis of intra-capsular fracture was proved, not only by the treatment, but by the post-mortem examination made two or three months after the receipt of injury. There was not the least attempt at union, and the end of the head had been partially absorbed. The anterior wire splint is used by Dr. Hewson for fractures of the thigh, and sometimes of the leg, and, while controlling the proximal joints, gives the patient greater freedom of motion during treatment.

In regard to shortening after fracture of the femur, it may be said that but little importance is attached to the amount, and measuring is rather at a discount. By a series of measurements of normal limbs, made by Dr. W. C. Cox a few years ago, it was found that there was a considerable difference in many cases where no injury had ever occurred. In fifty-four cases accurately measured only six showed the same length in both limbs, while fifteen cases showed a difference of a half inch or more between the two legs. The smallest amount of variation was one-eighth of an inch, while the greatest reached seven-eighths of an inch *(American Journal of the Medical Sciences*, April, 1875). As this has been well established, it seems useless to become agitated over shortening of one-sixteenth of an inch after fracture of the femur, which, by the way, may make the limbs more uniform than they were previous to the occurrence of the fracture.

The plaster of Paris dressing is seldom used except in cases of delirium tremens, when a rapid setting and solidifying is required to keep the bones steady, and preclude the possibility of the injury being made compound. Solution of silicate of soda is always ready, is so clean, and is applied with such facility that it is generally preferred, notwithstanding the fact that it takes several hours to become firm. The glue and oxide of zinc dressing of Dr. Levis is employed quite frequently also, the latter ingredient being added in the proportion of one part to eight or ten of glue, in order to increase the rapidity of hardening. None of these forms of fixed dressing, however, are applied immediately, as done in New York, but the patient is confined to bed for a series of days until pain and tumefaction have subsided, and often until considerable union has occurred.

—

The Caustics of Zinc.—Several physicians have consulted Dr. Squibb as to the best and safest manner of applying the chloride of zinc. The difficulty appears to be that the caustic cannot easily be limited to the part to which it is desirable to apply it; especially is this the case in respect of the application within cavities; for example, epithelioma of the cervix of the uterus, in which disease the chloride of zinc offers its best results. The excess of caustic gradually creeps down, comes in contact with, and plays the mischief with the vaginal walls; this takes place under the ordinary form of application by means of a pledget of lint, wet with a strong solution of the zinc, which is held in place against the diseased cervix by a tampon.

Dr. Squibb suggests, in the first place, that a less quantity of the caustic be employed, so that by its combining with the albumen of the diseased tissues, there shall be none to overflow upon sound tissues. Moreover, the upper layer of the tampon may be prepared with a carbonate of soda solution and allowed to dry before the application; the soda and excess of the caustic coming in contact, will re-combine and form a chlorinate, a sort of disinfectant. But the soda itself is an irritant, although not a caustic. It may be well to try carbonate of lime: dust the surface of the tampon, and thus disarm the zinc.

But, perhaps, better than these will be the use of the nitrate of zinc. It is less deliquescent, and very much more manageable than the chloride. Dr. Fisher has found it especially applicable within cavities. A hot, concentrated solution is made of the nitrate; into this a layer of cotton is dipped and then allowed to dry; the salt crystallizes in the meshes of the cotton, which can be adapted readily to the contour and irregularities of surface of epithelial growths and the like. This may be held in place by a tampon, which will absorb all excess of caustic.—*Proceedings of Medical Society of County of Kings*, N. Y., Jan. 1877.

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Deaths from Chloroform.—A case of this occurred at Rahway, New Jersey, on the 5th of January. A lad, aged 14, inhaled chloroform from a napkin prior to the extraction of a tooth. Immediately after the tooth was extracted there was a gasp for breath, a deep sigh, and the head of the boy rolled to one side and he was dead.

At a late meeting of the Obstetrical Society of Boston (*Boston Med. and Surgical Journal*, Jan. 11, 1876), Dr. Cotting remarked that since he came to the meeting an account of a case of death from chloroform during delivery had been shown him in the last number of the London *Lancet*, and stated that he had himself had, a number of years ago, a case in which death was probably due to the same agent. The patient was a primipara, aged twenty-two. The labour was going on well, and the head was apparently on the point of emerging, when the patient had a slight convulsion. Chloroform was administered, and, the pains returning after a while, the administration was repeated. The head was got away, and the uterus was contracting well, when a tremor occurred and the pulse ceased. The patient was dead. At the time of this occurrence there appeared to be no obvious cause of death; since then, as chloroform has been found to be frequently fatal, Dr. Cotting has been more and more of the opinion that death in this case resulted from the use of this anæsthetic.

—

Scarlet Fever in Boston.—From an official circular of the Boston Board of Health, dated Jan. 9, 1877, we learn that scarlet fever is now prevalent in that city. The board gives notice that every physician must hereafter report to the Board of Health cases of scarlet fever which he may be called upon to attend, and every householder must also give a similar notice of the appearance of scarlet fever within his family. An additional order of the board prohibits any child from any family in which scarlet fever may appear from attending school until four weeks have elapsed since the beginning of the last case of such sickness.

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The Medical Society of the District of Columbia.—At the annual meeting held Jan. 1, 1877, the following officers for the ensuing year were elected: Dr. S. C. Busey, president; Drs. Garnett and King, Vice-Presidents; Dr. L. Magruder, Corresponding Secretary; Dr. Klienschmidt, Recording Secretary; Dr. Franzoni, Treasurer; Dr. Patze, Librarian; Drs. Murphy, Smith, D. R. Hagner, C. E. Hagner, and Triplett, Board of Examiners; Drs. Elliot, Antisel, and Morgan, Board of Censors.

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University of Pennsylvania.—Dr. J. T. ROTHROCK has been elected to the chair of Botany in the Auxiliary Faculty of Medicine, vice Dr. H. C. WOOD, who was recently elected to fill the chair of Materia Medica, made vacant by the resignation of Prof. Carson.

The Professorship of Hygiene in the same faculty, has recently been vacated by the resignation of Dr. HENRY HARTSHORNE, in consequence of removal to Union Springs, New York.

—

Changes in Medical Journalism.—With the beginning of the new year, we have to chronicle the establishment of two medical journals, as well as the demise of another.

Toledo Medical and Surgical Journal.—The initial number of this journal was issued on the first of January, under the editorship and proprietorship of JONATHAN PRIEST, M.D., of Toledo. It is intended to be a monthly periodical of thirty-two octavo pages, containing original communications, reports of societies, correspondence, and editorials. Its publication has been undertaken, the editor informs his readers, in the belief that the profession is not so supplied as to hinder the success of another journal. We trust that Dr. Priest's journal may develop the merit which always insures success.

The Quarterly Journal of Inebriety, the first number of which appeared on the first of December last, appears as the official organ of the American Association for the Care of Inebriates, and is offered as the exponent of its principles. The journal will contain the transactions of the Association, with various other contributions from specialists in this field. It is under the supervision and editorial control of the publication committee, of which Dr. T. D. CROTHERS, of the Binghamton Asylum, is Secretary.

The Clinic.—With the commencement of its twelfth volume our sprightly contemporary passes under the editorial control of Dr. ROBERTS BARTHOLOW, whose reputation foreshadows the ability with which its columns will be managed.

The first number appears in a new and improved dress, and the journal will be published as heretofore at Cincinnati on every Saturday.

Peninsular Journal of Medicine.—With the December issue this journal closed its career. The Journal, we are informed, has consolidated with the *Detroit Review of Medicine and Pharmacy*, which will be henceforth published under the name of the "Detroit Medical Journal."

Obituary Record.—Died in Philadelphia, on the 30th day of December last, aged sixty-eight years, Joseph Carson, M.D., Emeritus Professor of Materia Medica and Pharmacy in the University of Pennsylvania.

During his long and distinguished career in the profession, Dr. Carson occupied many positions of honor and trust. He was for some years Professor of Materia Medica in the Philadelphia College of Pharmacy, and for subsequently twenty-six years Professor of Materia Medica and Pharmacy in the University of Pennsylvania. Among his contributions to medical literature in addition to numerous fugitive lectures may be mentioned his Illustrations of Medical Botany, published in 1847, his edition of Pereira's Materia Medica, and the History of the Medical Department of the University of Pennsylvania. At a later day we hope to present to our readers an appreciative biographical sketch of Dr. Carson.

At a meeting of the Medical Faculty of the University of Pennsylvania, held January 1, 1877, in relation to the death of Emeritus Professor Joseph Carson, M.D., the following minute was unanimously adopted:—

The Medical Faculty have heard with profound sadness of the death of their late colleague, Dr. Joseph Carson, who for twenty-six years occupied the Chair of Materia Medica and Pharmacy with a distinction and authority to which a life-long devotion to these branches of science entitled him. His complete mastery of his subject enabled him to give to each part of it in his lectures a due weight and proportion, and to impress his class with the soundness of his instruction.

Throughout his whole career he was beloved by the students for his kind and gentle manner, and the wise and affectionate interest he displayed toward all who sought his counsel, and especially to his private pupils, who, in after life, delighted to renew their acquaintance with their former teacher and friend.

In the medical faculty he was not less beloved for his simple, cordial, and sincere manners and his perfect truthfulness and directness of purpose, than he was respected for his loyalty to the school whose history, traditions, and capabilities he was best acquainted with, and for his desire to reconcile the exigencies of its position with its duties to medical teaching and to the medical profession.

His former colleagues can never forget their meetings, which were rendered cheerful by his social qualities and satisfactory by the wise discretion of his counsel.

Resolved, That the Faculty will attend in body the funeral of Dr. Carson on the 2d instant.

Resolved, That the Faculty tender their warmest sympathy to Dr. Carson's family in their bereavement, and that a copy of these proceedings be sent to them, and one also to the Board of Trustees of the University of Pennsylvania.

FOREIGN INTELLIGENCE.

Treatment of Scarlet Fever with Sulphur.—Mr. Henry Pigeon, of Clifton, England, writes to the *Lancet* (Nov. 25, 1876) that "the marvellous success which has attended my treatment of scarlet fever by sulphur induces me to let my medical brethren know of my plan, so that they may be able to apply the same remedy without delay. All the cases in which I used it were very well marked, and the epidermis on the arms in each case came away like the skin of a snake. The following was the exact treatment followed in each case: Thoroughly anoint the patient twice daily with sulphur ointment; give five to ten grains of sulphur in a little jam three times a day. Sufficient sulphur was burnt twice daily (on coals on a shovel) to fill the room with the fumes, and of course was thoroughly inhaled by the patient. Under this mode of treatment each case improved immediately, and none were over eight days in making a complete recovery, and I firmly believe in each it was prevented from spreading by the treatment adopted. One case was in a large school.

"Having had a large experience in scarlet fever last year and this, I feel some confidence in my own judgment, and I am of opinion the very mildest cases I ever saw do not do half so well as bad cases do by the sulphur treatment, and, as far as I can judge, sulphur is as near a specific for scarlet fever as possible."

—

Transfusion.—An unexpected opportunity was afforded Dr. Roussel on Saturday last (the 9th inst.) of exhibiting his ingenious apparatus for the transfusion of blood upon a patient in the London Hospital. The case was that of a boy, under the care of Mr. James Adams, suffering from advanced disease of the hip, with evidence of amyloid changes in viscera, and œdema of the affected limb. It was decided to perform amputation at the hip-joint, and ether was administered and Esmarch's bandage applied. The patient, who was extremely prostrate and anæmic, lost no blood during the operation, but the pulse became extremely weak and small. Dr. Roussel happening to be present for the purpose of giving a demonstration of his apparatus to the students of the hospital, it was determined to take advantage of the opportunity thus afforded, and to perform transfusion at once. Accordingly, without continuing the operation after removing the limb and tying the arteries, Mr. Adams supplied six ounces of blood from his own arm to his patient on the table before him. The latter improved notably after the transfusion, the pulse becoming firmer and more full, but the pallor persisted; whilst the surgeon, with his arm bandaged after the venesection, proceeded on his way with the rest of the operation. We regret to learn that, although the lad rallied from the immediate effects of the operation, he succumbed two days after. —*Lancet*, Dec. 16, 1876.

—

Death from Chloroform.—We learn from the *Medical Times and Gazette* (Dec. 16, 1876), that a death from chloroform took place at Charing-cross Hospital on December 8. The deceased was about to be placed under the influence of the anæsthetic to facilitate the application of the taxis for the reduction of a hernia. Very little chloroform had been given, when suddenly alarming symptoms showed themselves; and although the chloroform was stopped at once and restoratives were applied, death took place immediately.

—

A Ready Method of testing Urine for Albumen.—Mr. W. Henry Kesteven recommends (*Med. Times and Gaz.*, Dec. 23, 1876) the following method. Take a piece of thin glass, such as is ordinarily used for microscopical covers; about one inch square is the best size. On the surface of this, slightly to one side of the centre, place about two drops of the urine to be tested; on the other side of the centre place one drop of nitric acid. By gently inclining the glass the two fluids will mix, and any precipitate that is formed will be readily seen when the acid-fumes have passed off. The precipitate may be rendered more apparent by covering the reverse side of the glass with Brunswick black or some other such pigment. Another method of using the thin glass cover is one which will be found particularly handy for use at the bedside. The urine should be placed on the cover as above, and then, with an ordinary pair of dresser's forceps, the slip of glass should be held over the flame of a candle. By so doing the albumen, if present, will be precipitated, and rendered plainly visible by the blackening of the glass with the smoke of the candle. This last method should be practised with care, as, if the glass is held too close to the flame, violent ebullition of the urine takes place, with rapid evaporation. The value of the use of these thin glass covers for this purpose consists mainly in the ready way in which the urine can be tested by means of them. It is very easy to carry a few of them in the pocket-case for use by those who prefer the warm method of testing; whilst for those who prefer to test the urine cold with the acid, a box could easily be contrived which would carry one or two blackened covers and some nitric acid.

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Colour-blindness and Railway Service.—We are glad to learn, on the authority of Mr. Mason (*Lancet*, Jan. 6, 1877), that so much care is taken on most of the British railway lines to test the vision of the servants of the company. The testing itself is, however, or rather should be, a scientific affair. It cannot be hastily settled by showing a man a few pieces of paper and asking him to name the colours. Even in the healthy eye the extreme lateral parts are incapable of perceiving red. Objects of that colour, which are carried to a little within the verge of vision, suddenly become black, whilst they resume their red tint on being brought forward again, which is not the case with blue or green objects, and it is possible that the red-perceiving elements of the retina may have areas of distribution of different magnitude in different instances. The examination should be made with coloured glasses, and with the aid of a perimeter. We can hardly agree with Mr. Mason in considering cases of downright ignorance of the names of cardinal colours to be more numerous than those of Daltonism. He states that he found "a man, represented as colour-blind, called 'red' yellow, and 'green' red, quite able to appreciate them and small differences in shade of each of these colours, and who quickly became colour perfect by the same process as a schoolboy learns the alphabet." We should have passed such a man as (in this respect) a trustworthy railway porter only after repeated trials, if at all. His new knowledge might have failed him at a critical moment, and he would certainly have been long in a state of confusion. The fact that different shades of the same colour can be distinguished is by no means uncommon, even in cases of well-marked Daltonism. In a recent work of some authority, Bernstein on the "Five Senses of Man," we observe that colour-blindness is stated to occur nearly in the proportion of one in twenty of the population. If this is based on good authority, it must be far more frequent in some nations and localities than in others; for, even granting that it is frequently passed by unnoticed at ophthalmic hospitals, or that the subjects of it rarely apply for relief, it certainly does not exist in anything like that proportion in England. Mr. Haynes Walton calls attention to the fact, otherwise well known, that colour-blindness may be acquired. An impairment of the power of distinguishing shades of colour is not uncommon in cases of amblyopia, from whatever cause this may arise; and, as Mr. Walton suggests, it would be well that periodical examinations of the capacity of officials in regard to perception of colour, on which so much of the safety of the public depends, should be made.

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Medical Society of London.—At a meeting of this venerable society held on the 6th of November last, it was unanimously resolved by the society "to exclude persons of the female sex from either becoming fellows of the society or from being introduced to it as visitors."

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Professor Valentin's Jubilee.—Professor VALENTIN, of Berne, the discoverer of ganglion cells and ciliated epithelium, celebrated the fortieth anniversary of his academical career on November 6, and was presented by the Medical Faculty with a congratulatory address and a bronze statue of himself. The Philosophical Faculty also gave him a doctor's degree *honoris causâ*.—*Med. Times and Gaz.*, Dec. 16, 1870.

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OBITUARY RECORD.—The celebrated naturalist, VON BAER, whose name is closely connected with the study of embryology, died on November 28, at the age of eighty-five.

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It will be seen from this that the scope of this work is not dissimilar to the well-known "Principles of Medicine," by Dr. J. C. B. Williams, now long out of print, which in its day met with such unusual acceptance. More practical in its character, however, it seeks to bring to the aid and elucidation of positive therapeutics, the vast accumulation of scientific facts and theories made by the present generation, pointing out the measures to be adopted at the bedside, and establishing them on firm rational grounds. Such a work, by a first-rate man, and fully up to the advanced condition of science, cannot fail to prove of the utmost service to both student and practitioner.

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HENRY C. LEA—Philadelphia.

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CLINICS.

CLINICAL LECTURES.

Clinical Remarks on Diffuse Sarcoma of the Uterus. By John Clay, Obstetric Surgeon to the Queen's Hospital, Birmingham.

Gentlemen: The patient from whom you saw me the other day remove some morbid growths from the interior of the uterus, is, as I stated at the time, suffering from diffuse sarcoma of the uterine mucous membrane. During the last three years we have had under treatment in the hospital six other cases of disease of the same nature, and therefore in to-day's lecture I have thought it advisable to comment upon them collectively, as they present important features in common, while they exhibit peculiarities which can with the greatest advantage be considered in this manner.

I may remind you that sarcoma of the uterus occurs in two forms: one more or less solid, which, as it increases in size, constitutes a distinct tumour, and, when examined under the microscope, is found to consist principally of fusiform cells; the other, the diffuse form just mentioned, in which small round cells predominate. The division between these two forms of uterine sarcoma is, however, not always sharply defined. Both forms of the disease, moreover, are marked by features common to other diseases of a benign character, and very frequently

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curable, while the cases of sarcoma which we are considering always have a fatal termination. The interest of this disease is much enhanced by the fact that the treatment usually recommended for its alleviation is precisely that which is adopted for the cure of the similar diseases of a benign nature.

The symptoms presented by the seven patients now under notice were tolerably uniform, with the exception of some urinary complications, which occurred in two of the cases. The following is a brief summary of the history of the patients and the symptoms which they presented. Six of the patients were married, and were wives of persons of the operative class. Their ages ranged from thirty-two to forty-one years. All of them had given birth to children, the smallest number being three, and the highest eight. Only one patient had aborted, and this occurred eight years previously to coming under observation, and she had since had two children at term. None had borne children for four years previously to treatment, and in the case of one patient it was sixteen since her last pregnancy. One patient, aged fifty-two, a housekeeper, was unmarried, with the hymen firm and intact. In her case menstruation had ceased nine years. Thirteen months before applying at the hospital a sanguineous discharge appeared after she had returned from a long walk, and this discharge continued in an excessive degree for three days, when it suddenly ceased, leaving her much exhausted. This was followed by a free, thin, and turbid discharge, which troubled her very much on account of its peculiar rather than offensive odour. She had three subsequent attacks of hemorrhage at four, five, and nine months' interval respectively, and in each instance it was followed by the same serous discharge. The patient was at these times treated medically, but she derived little benefit from the treatment. All the patients applied for medical aid in consequence of menorrhagia. In the cases of the six married women the commencement of the disease was uncertain. The menstrual periods were at first tolerably regular, but were marked by an increased sanguineous discharge, which increased at each period, and also continued longer, until at the time of admission into the hospital the discharge was almost continuous. It is worthy of remark that for several days previous to the regular period the discharge was more of a watery nature tinged with blood, being described as very pale; clots were noticed only at certain times, probably corresponding to a menstrual period, and then the discharge was more of a true hemorrhage, being of a bright-red colour. Pain, as a rule, was experienced only on these occasions, and was of an expulsive character, similar to that which is observed in some forms of dysmenorrhœa. Occasionally the coloured discharge would cease for a few days, and would then be followed by an almost odourless watery discharge, sometimes so abundant as to require the use of several napkins daily. The patients were all anæmic, with impaired appetite and œdema of the lower extremities. They were all remarkably free from nervous and hysterical phenomena.

The objective signs furnished by the patients were tolerably uniform. On palpation the uterus was found to be enlarged. Per vaginam, the os uteri was soft and thickened, its condition otherwise being normal, but invariably patulous, readily admitting the finger. The cavity of the uterus was enlarged, permitting the finger to move easily to explore the uterine cavity. One part of the uterus was felt to be thickened—cushioned as it were; and this part was rough to the touch, and largely studded with prominent growths varying in size from a pea to a hazel-nut. In other parts of the uterus smooth spaces were discernible. In one case the irregularity of surface appeared to be general. The space occupied by these growths was about half of the uterus, and was generally on the posterior surface. In the unmarried patient there was a space of about the size of a crown-piece at the fundus, which seemed to be denuded of mucous membrane; it was also dry and fissured. Just above the posterior part of the cervix, in one patient, there was a growth of the size of a cherry, which after removal was found to contain both fusiform and round cells. In two of the cases the os and cervix were slightly thickened, and were soft, as if infiltrated with serum. By the use of the sound the uterus was found to measure from four to five inches. The employment of the sound was generally followed by hemorrhage, occasionally lasting for hours. Bladder complications were absent in five of the cases, and in these there was no displacement of the uterus, and there was also complete mobility of this organ. Two of the patients—the unmarried one, and the married one who had not been pregnant for sixteen years—suffered from retroflexion of the uterus, with retention of urine; and had, in fact, all the symptoms of retroversion of the gravid uterus, these being undoubtedly caused by the enlarged, weighty uterus. The urine had to be drawn off two or three times daily for about a fortnight, and several kinds of mechanical appliances were employed to remedy the displacement, but without effect—seeming, indeed, only to aggravate the sufferings of the patients. It was not until the growths were removed that the more urgent bladder symptoms were relieved, and a Hodge's pessary could then be worn for a time with comfort; but in both cases, after removal of the growths, the disease returned, the uterine walls being covered with the same kind of growths as before, and this was again complicated by the return of the urinary troubles. Further operative measures were objected to by both patients, and they left the hospital. I learned subsequently that they died in a few weeks after great suffering, the bladder symptoms being especially distressing.

The treatment pursued in all the cases consisted in carefully removing the growths with a Sims's curette. The quantity removed varied from a dessertspoonful to two-thirds of a teacupful. The growths always exhibited the same grayish-white, vascular, brain like appearance, and varied from the size of a pea to one somewhat larger than a horse-bean. The operation was invariably followed by a copious hemorrhage, to arrest which perchloride of iron in solution was injected into the uterus, and this succeeded in arresting the bleeding. It was never necessary to dilate the os uteri with sponge tents before using the curette. There was but little reaction after the operation, and the patients left the hospital in less than a week, being then made out-patients, and placed under a course of treatment of which the ferruginous tonics were the principal element. Pepsine was used by insufflation twice a week.

As already mentioned, the disease returned in all the cases, the patients displaying symptoms similar to those which they manifested before the operation. The period of return ranged from two to fourteen months. In three of the cases the operation with the curette was repeated with temporary benefit. The result of the seven cases was, that five died out of the hospital from hemorrhage and exhaustion, as was gathered on inquiry at their homes; there being no post-mortem examination made in any of the cases. The two patients with urinary complications died comatose, probably the consequence of uræmic poisoning, as I found that towards the last there was great difficulty in evacuating the urine. Two patients are probably still living; but the last time they visited the hospital there were unmistakable signs that the disease was returning.

It is generally considered that the two forms of uterine sarcoma cannot always be separated clinically, or even anatomically, with the exactness which the physician might desire; yet we find in the cases to which I have directed your attention that the form of the disease was always clearly manifest, and that it always presented the same signs—namely, those indicative of the diffuse sarcoma. No distinct tumour of a fibrous nature existed, or even a tumour of that structure modified by softening or ulceration. The physical characters of a fibrous sarcoma, and even the symptoms, may be changed by the supervention of these processes, the growths assuming different forms; and so dissimilar are some of its phases that it seems to belong to a totally distinct class of disease. Practically, however, the range of diseases with which fibrous sarcoma might be confounded is diminished under these altered circumstances, and consequently the diagnosis is much simplified. It is of great importance to endeavour to form correct views of the diagnostic points of the diffuse form of sarcoma at an early period of the manifestation of the disease, as probably some means might then be devised of removing it altogether. There is no doubt that we require more information than we now have of the nature and means of treatment of this malady, but by the light afforded by the cases now under consideration there does appear to be a hope of something more effectual being done towards its cure than has hitherto been attempted. A great advance has been made recently towards the elucidation of the true nature of this disorder. The foremost place must be assigned to Virchow, as his researches have powerfully stimulated inquiry into the nature of these diseases, which have thus been rescued from the obscurity and uncertainty by which they were for a long time surrounded. Subsequently to his researches, several German pathologists have published valuable essays of a practical nature. Of these Ahfeld and Hegar have done much to illustrate the diffuse form of the disease. Other writers have contributed to the literature of the subject, but the writings of most of these—notably those of Professor Simpson—have more particular reference to fibroid sarcoma, with a view to differentiate it from cancerous growths. The valuable and remarkable essay of Olshausen "On Chronic Hyperplastic Endometritis," is worthy of especial mention in connection with this subject, as a careful study of it, and a comparison of its conclusions with the essays on sarcoma previously referred to, render it almost impossible to confound the latter diseases with any other morbid condition of the body of the uterus; and although the phenomena of the two classes—the benign and the malignant—run closely parallel, yet, when carefully examined, they will be found to repay the closest scrutiny. The controversies which have lately engaged the attention especially of German pathologists with respect to this disease have a special interest for inquirers, and the question is of such importance from a therapeutical point of view that it merits the sustained attention which uterine pathologists are giving to it. These circumstances impart revived interest to the treatment of the "uterine fungosities" practised by some French physicians nearly forty years ago, as it is to them we are mainly indebted for the principles of the method of treatment now adopted for removing morbid growths from the interior of the uterus by means of the curette. The facts collected by Rouyer and Goldschmidt in their valuable theses on Uterine Fungosities are of great importance, and the large number of cases which they describe illustrate the different methods of treatment, and are creditable to their industry, forming, indeed, a valuable *résumé* of the previous experience of Récamier, Nélaton, and others. It must, however, be acknowledged that pathologically they are not of much value, as there is no doubt that, under the title of uterine fungosities these writers included several conditions which cannot properly be grouped together, such as villous growths of the mucous membrane, chronic hyperplastic endometritis, and some other forms of disease.

The subjective and objective phenomena furnished by the patients whose epitomized history I have given you supply a tolerably fair account of the symptoms of this interesting disease, and are sufficiently explicit to require only brief comments upon them. The ages of the patients and the regularity of the menstrual periods show that in the majority of the cases the disease commenced during the period of sexual vigour. Only one case occurred nine years after the cessation of the menses. It is not evident that difficult parturition or abortion had any connection with the causation of the disease, as, on careful inquiry into the character of the labours, they may be generally pronounced as having been very good. Most of the patients had lived the greater part of their lives in the country, and were fairly tall, well-proportioned, and well-developed women. In each case it was on account of suffering from menorrhagia that the patients were led to apply at the hospital for relief. The date of the appearance of this symptom in all the married cases was uncertain. The discharge was first noticed to be increased in quantity at the regular periods; after two or three months the duration of the periods was also found to be increased; and after a few months the discharge became almost continuous, so that there seemed to be scarcely any intermission, and in the intervals which did occur there was an abundant watery discharge, this, especially later in the disease, being more or less freely tinged with blood. It would appear that in diffuse sarcoma there is always menorrhagia; while its absence in the fibroid form is more easily explained by the nature of the tumour, and the fact that sloughing and ulceration of it have not occurred. The important point to be borne in mind is, that you must not consider an increased flow of blood at the menstrual periods, constituting menorrhagia, to be the result alone of general causes (a conclusion which has become more prevalent of late), but that when it may be considered fairly chronic, and when it is alternated with watery discharges, you must suspect that it arises from local causes, and therefore demands careful and special investigation. When the disease has existed some time, the patient is generally very pale; there is also the peculiar sallow colour so marked in advanced malignant disease, this condition being chiefly caused by the excessive drain on the system produced by sanguineous and watery discharges. Dr. Thomas states that the great vascularity of the growths in diffuse scarcoma is the cause of these discharges, and in describing the attendant phenomena he says that it rapidly proceeds to fetid ulceration. This, however, is not our experience, as the discharge was not fetid in any of the cases now under consideration, and the absence of sloughing and ulceration was often commented upon. The ordinary uterine exploration undoubtedly easily excited hemorrhage, and probably this was occasionally produced by the contractions of the uterus; but it is a noteworthy fact that the amount of hemorrhage was out of all proportion to the apparent ulceration. It probably may be explained by the general hyperæmia of the mucous membrane of the uterus. Sometimes a single mucous polypus gives rise to, or may be accompanied by, a profuse menorrhagia. In such a case the hemorrhage evidently does not arise from any breach in the structure of the growth; and when the growth is removed the hemorrhage ceases, probably because the source of irritation—the cause of the hyperæmia—is removed. It is obvious that several authors who have contributed to the pathology of this subject have confused the two forms of the disease in their descriptions. The hemorrhage occurs more constantly in the diffuse sarcoma; while it is more occasionally met with in the fibroid form, in which it depends more upon the sloughing and ulceration of the growth than upon any local hyperæmia, and naturally varies in quantity as circumstances increase or diminish the circulation of blood in the uterus. The almost entire absence of pain seems to be an important feature in diffuse sarcoma, and is a valuable aid in the diagnosis. The pain is chiefly due to the contractions of the uterus, evoked to expel coagula formed and retained in the uterus during an increase of the sanguineous discharge. I may here mention the allegation that secondary growths in other parts of the body are likely to occur in sarcoma of the uterus; in our cases, however, there was no evidence of them. The results produced by absorption of septic material are of more probable occurrence.

You will find that the diagnosis of disease of the interior of the body of the uterus is frequently attended with considerable difficulty, especially at an early period of its development. This particularly applies to the disease we are now considering. In the diagnosis, it is advisable first to decide between the presence of the two forms of sarcoma. The fibroid sarcoma has more or less fibrous tissue entering into its composition, and consequently is harder, thus forming a more distinct tumour according to the degree in which such tissue preponderates. Therefore, if you have this kind of growth under examination, whatever may be its varying degree of development, you cannot well confound it with the diffuse form. The latter form is clearly a distinct disease ; and, as far as my experience guides me to a conclusion, I may say that I have never seen this form assume a homogeneous mass, so as to constitute a distinct and increasing tumour. From the nature of its composition we must consider it a round-celled sarcoma; otherwise, from its anatomical and clinical characters, it might be regarded as altogether another disease, so different is it from the more solid form. Excluding the solid growths, by this mode of investigation the papillomata and the various forms of fibrous and sarcomatous polypi are removed from consideration ; and our attention is confined to the diagnosis between cancer of the body of the uterus and chronic hyperplastic endometritis, as the phenomena to which these diseases give rise are common to diffuse sarcoma of the uterus. It is scarcely necessary to mention mucous polypus of the uterus, as the pedicellated character which this generally assumes enables it to be easily recognized. Menorrhagia and more or less watery discharge are always prominent symptoms, and almost always indicate the presence of some structural lesion, and are therefore common to all the diseases just mentioned. The almost entire absence of pain serves in some degree to distinguish this disease from cancer of the body of the uterus, as the pain of the latter is excessive, and is of a neuralgic character rather than of the expulsive nature of the pain which is sometimes met with in advanced stages of diffuse sarcoma. These signs, it is evident, do not afford much diagnostic information, and we are forced to arrive at a conclusion by the only certain means—*i. e.*, a digital examination of the interior of the uterus, and a removal of a portion of the growth for ocular and microscopical examination. I have mentioned that the os uteri in our cases was sufficiently dilated to admit the passage of the finger; but it is not always so, especially in the other diseases I have named. If, however, it is found to be closed, the os uteri must be dilated by sea-tangle or sponge tents to a sufficient extent to admit the finger. This being effected, and the finger being introduced into the uterus, counter-pressure must at the same time be made on the abdomen in order to bring the uterus within reach of the finger. If it is a case of diffuse sarcoma, we shall find upon some one part of the uterus (rarely all over it) several distinct growths, which arise from what is felt to be a thickened basis, the size of the growths varying perhaps from that of a pea to that of a hazel-nut. In chronic hyperplastic endometritis, this thickened basis, if present, is not so marked, and the growths are not so prominent, indicating, on being touched, a broader attachment, a mere roughening, as the growths do not attain a larger size than that of a grain of wheat, or at least an elevation of that size. In cancer of the fundus of the uterus, the growths at first show themselves in roundish protuberances on the walls of the uterus, which, in consequence of the encroachment on the cavity of the organ, become enlarged at an early period of the disease; and these growths may even be felt to protrude on the exterior of the uterus. If these growths or nodules soften and ulcerate, they might be confounded with sarcoma; but in cancer of the fundus the tendency is to produce a depression or excavation instead of a thickening of the tissue—in short, to form a large ulcer, with a somewhat hard and irregular margin; while in sarcoma the disposition of the growths is to become aggregated and to form masses, which push their way into the cavity of the uterus, and may, in some cases, be eventually expelled in consequence of a sloughing process supervening. Even here, however, we have not the excavated ulcerated surface just mentioned as peculiar to some forms of advanced intra-uterine cancer.

We are, therefore, forced to the conclusion that the existence of diffuse sarcoma cannot be determined otherwise than by an ocular or microscopical examination of a portion of the growths, removed for the purpose of examination. I say ocular, because those of you who a few days ago saw the case of chronic hyperplastic endometritis in which the curette was used, and who also saw the structures removed in the case of diffuse sarcoma, cannot be satisfied that, upon examination of the growths removed, their nature may with some degree of exactness be fairly ascertained from their appearance alone. If we compare these growths with those removed in the case of endometritis, the latter are seen to be intensely hyperæmic, and under the microscope they show an increase of all the elements of the uterine mucous membrane—dilated follicles with abundant cell infiltration of the connective tissue; while in diffuse sarcoma the growths are of a grayish-white colour, very vascular, and presenting a soft, brain-like consistence, and are capable of being easily crushed between the fingers. Under the microscope they are found to consist of innumerable small round cells, surrounded by intercellular substance. It is no doubt somewhat difficult to diagnose cases of diffuse sarcoma by a digital examination, but having due regard to the symptoms as a whole, and to the appearance of the growths removed, we may in many instances fix the nature of the disease by this means alone. It is but right, however, to say that ulceration and sloughing of the mass may so alter its appearance that the use of the microscope may be required for an absolute decision. Then, noting the absence of cancer cells and of cells peculiar to other growths, the true nature of the case is at once demonstrated.

The treatment consists in removing the growths by means of the curette. I employed Sims's, which in every case completely fulfilled my expectations. Assuming that the os is dilated, and having by previous examination ascertained precisely the seat of the growths, the curette is to be applied cautiously to this part, going over the diseased surface. The action of scraping removes the growths from the uterus, and brings them into the vagina, whence they may easily be dislodged by using a free stream of water by means of Higginson's syringe. After each operation a smart hemorrhage followed, and with the view of arresting this, and of producing a favourable change in the diseased parts, a solution of perchloride of iron was injected into the uterus. This generally stopped the hemorrhage, and promoted a more normal condition of the interior parts. The results of this method of treatment were so satisfactory that the patients were generally able to be placed in a few days on the list of out-patients. In these cases insufflation with pepsine was used afterwards. When from its use the pain became very severe, which occurred after three or four applications, powdered nitrate of silver with charcoal in powder was used with the insufflator, and proved efficacious for a time, but, as previously stated, the disease generally returned. It is of course necessary to support the strength of the patient, and to remove the anæmic condition, as far as possible, by the use of a generous diet, aided by the administration of tonics, of which iron in some form should be the chief.—*Lancet*, Jan. 6 and 13, 1877.

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Abstract of a Lecture on the question, When is the Catheter to be used for Habitual Retention from Hypertrophied Prostate? By SIR HENRY THOMPSON, Surgeon Extraordinary to H. M. the King of the Belgians, Emeritus Prof. of Clinical Surgery in University College Hospital.

There is a question which arises in the treatment of these cases which sometimes demands careful consideration. It is, "What are the circumstances which should determine us to commence habitual catheterism for a patient whose hypertrophied prostate prevents him from emptying the bladder by his own efforts?" I reply that there are at least two principal facts relating to the local symptoms which must be noted in arriving at a judgment for any particular case. Firstly, we must know the amount of "residual urine" habitually present—that is, the quantity left behind in the bladder after the patient has passed all he can by his own efforts; and, secondly, we must observe the degree of frequency, by day and by night, with which he passes water, but especially during the latter period.

In reference to the first particular, the amount of "residual urine," you will of course not always judge from one trial of the catheter. Where there is nothing to disturb the function of micturition—and it is very easily disturbed, as by the presence of a stranger, or by the requirement to perform the act for purpose of experiment when a natural want is not present—the amount of urine left in the bladder is pretty uniform with most patients; the conditions just referred to often temporarily impairing the expulsive power, and rendering therefore the residual portion on the occasion of examination rather larger than usual. This understood, let us suppose a case in which eight ounces always remains behind. That quantity suffices, in my opinion, to make it desirable that the patient should at once commence the daily use of the catheter. But you may find a much smaller quantity; and you are entitled to ask me—indeed, I expect you to do so—"What is the point in regard to quantity at which the line is to be drawn? When can I say, With this quantity a catheter is quite unnecessary; or, With such a quantity there is no doubt it must be used?" No answer can be given to such a question. The data from which to form a correct judgment are not contained within the terms of the proposition. Other facts are to be ascertained. I have heard it laid down, indeed, as an axiom, that so long as the urine is clear, no matter what the quantity retained, no instrument ought to be employed. A certain amount of *à priori* reasoning may be urged in behalf of such a rule, but it will not bear the test of large experience. The problem presented for solution in this, as in most other cases where surgical interference is imminent, is far too complex to be solved by one unvarying rule. Like the statement respecting quantity referred to above, the single fact that the urine is clear does not suffice to govern your decision. A large quantity of residual urine, much more than a pint, may exist, clear and acid in certain cases, but which, as we shall hereafter learn, ought certainly to be drawn off by catheter.

But let us see what this rule of never withdrawing the urine while it is clear means or involves. It means neither more nor less than waiting for the occurrence of chronic cystitis before we use an instrument! No other inference is possible. And why should we wait for chronic cystitis?—a condition which of all others it is highly desirable to avoid in an old and already incompetent bladder, leading as such an affection naturally does to thickening of tissues and loss of extensibility on the part of the organ. Is it not, on the contrary, the very condition we desire to avoid, and do mostly avoid, by commencing the use of the catheter at a sufficiently early period? Of course I know full well that in past days, when catheterism necessarily meant the use of the large metallic instrument, often painfully passed, to say the least, chronic cystitis was an ordinary and frequent result of catheterism. But it rarely is so now, with the soft and flexible instrument of moderate size, if only it is used at an early period in the case, and before considerable accumulation has taken place; the removal of a large quantity being mostly, I do not say invariably, followed by local and general disturbance. For it is not very common to find a patient whose residual urine has, from neglect of catheterism at an early period, reached the quantity of twenty ounces or more, who does not suffer somewhat severely from both chronic cystitis with purulent urine, and febrile attacks with resulting debility, whenever the daily use of the catheter has to be commenced. Furthermore, at this advanced stage of chronic retention, a slight accident of some kind readily occasions complete retention, or nearly so; and then it is no longer a question of using or not using the instrument, since the condition is now one which imperatively demands a catheter. In these last named circumstances, chronic cystitis is almost sure to follow—an occurrence which most probably would not have happened had there been an earlier resort to the instrument. And so it happens, in the management of these cases of continued and chronic retention due to slowly advancing hypertrophy of the prostate, that the longer the use of the catheter is postponed after the early stage of the malady is passed, the worse will be the symptoms. And it happens, also, unhappily not seldom, that these serious symptoms following the use of the catheter bring undeserved discredit on the surgeon who first employs it—a discredit really attaching solely, and very gravely too, to the adviser who unwisely prevented an early resort to its aid. So that I beg you to understand that with a quantity of habitually retained urine amounting to eight or ten ounces, whether it be thick or clear, there is no question in a vast majority of cases that the time for the catheter, say, at least once, probably twice a day, has arrived.

But what other circumstance has also to be taken into account? A very important one, viz., the frequency with which the patient passes urine, and which differs greatly in different cases. It is much more to the purpose for your decision to note whether the patient is disturbed six times in the night or only twice, than whether his urine is clear or cloudy, or even whether the residual urine amounts to four ounces or to twelve. If you find him affected by loss of rest—one of those things which sap the foundations of life in elderly men—pass the catheter the last thing at night for him, and mark the result. If he obtains four or five hours of continuous sleep after the bladder has been emptied—a common occurrence—you have reason enough for persevering, and he will learn to use the instrument himself every night, and will be exceedingly grateful to you for the relief he has obtained. So also the avoidance of pain and spasm by this treatment—a result which is often to be noted—makes it highly desirable, whether the quantity drawn off be small or large, transparent or clouded by mucus. Taking into consideration these different phenomena, which vary so largely in different constitutions, you will have no difficulty in arriving at a correct judgment for each individual case, provided you give to each sign or symptom its due importance, and do not rest your decision on any one, unless that one—in regard of quantity, for example—is sufficiently marked to leave no ground for doubt as to your course.—*Lancet*, Jan. 6, 1877.

HOSPITAL NOTES AND GLEANINGS.

Case of Rupture of the Aortic Valve.—The following case, treated at the North Staffordshire Infirmary by Dr. ORTON, is interesting alike from the unmistakable character of the evidence of the cause and nature of the injury, and the peculiar symptoms which supervened.

James C——, aged forty, married, was admitted on October 19, 1876. He had always enjoyed good health, never had had rheumatic fever, or any other severe illness. At Christmas, 1875, while lifting a heavy weight, he felt something suddenly snap in his chest. He immediately fainted, and was conveyed in an unconscious state to the Liverpool Infirmary, remaining insensible till next day. Ever after the accident he could hear a sound in his chest, which he described as like a "pigeon cooing." About a week after the injury he had a severe attack of cough and hæmoptysis. The cough did not trouble him for more than about three months, but the hæmoptysis continued. He was not able to get out of bed from the first, and had to be propped up with pillows to relieve the dyspnœa. He gradually lost flesh, and became very weak.

On admission he complained of pain in left mammary region and epigastrium, and of great palpitation. There was slight cough, with scanty expectoration, the sputa being tinged with bright blood. He suffered from orthopnœa. There was no œdema of ankles. Urine sp. gr. 1005, no albumen. The heart's impulse was very strong; the left cavities were hypertrophied. A loud, harsh bruit could be heard with the second sound, loudest over the aortic valves, but transmitted to the apex, and also round towards the axilla, and up the carotids. The "water-hammer" pulse was marked; pulsation was visible in the carotids, radial, brachial, and other superficial arteries. Giddiness and faintness supervened on the slightest exertion.

The treatment adopted did not differ from that of an ordinary case of aortic valvular insufficiency.

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Case of Pannus of the Cornea treated by a free Incision of that Membrane.—Ada W——, aged thirteen, was admitted into the Birmingham Eye Hospital, under the care of Mr. J. Vose Solomon, on Nov. 13th, 1876, with pannus of both corneæ. She complained of severe pain which prevented sleep.

The central third of the cornea of the right eye presented a yellowish white infiltration, which projected forwards, forming a cone. The rest of the membrane and the sclera were uniformly scarlet, the colour being derived from numerous vessels; no ecchymosis. The whole of the cornea and sclera of the left eye presented a uniform scarlet surface; no extravasation of blood. In neither eye was the corneo-scleral boundary discernible.

With a view to the alleviation of pain, and the prevention, if possible, of sloughing, and consequent staphyloma of the cornea, a free vertical incision with a Gräfe's knife was immediately made through the whole width of the right cornea; a compress and bandage were applied to both eyes, and kept wet with belladonna lotion. The body of the patient was ordered to be anointed night and morning with refined neat's-foot oil, the patient to remain in bed for at least a week; ordinary diet.

Nov. 16. No pain since the operation; sleep restored. The right eye is less vascular; the left has undergone a remarkable improvement, patches of opaque cornea being now visible.

20*th* (seventh day after operation). The whole of the left cornea is visible; it is opaque; no pannus; thin vessels traverse the membrane at intervals. Vascularity of the right eye much diminished; area of central exudation lessened; a tenacious purulent-looking material (pus and débris of corneal tubes?) projects from the wound, which is about a line and a quarter in length, the remainder having cicatrized.

24*th*. Omit lotion; dry dressing to be applied, also atropine drops.

27*th*. The central opacity of the right eye is white.

Dec. 4. An asthenic central ulcer has perforated the cornea.

5*th*. The patient left the hospital for home, which is in the town.

7*th*. Ulcer of the cornea healed, and normal convexity restored; vascularity diminished.

15*th*. Both corneæ are clearing, which permits of a view of a part of each pupil.

Remarks. In the first volume of *Braithwaite's Retrospect* for the present year I have given some account, with cases, of the "Value of Incision of the Cornea" in serious diseases of inflammatory origin, to which the reader of the present illustration of the practice is referred. Of the gradual restoration of Ada W——'s sight I have no misgivings. It will be noticed that the old practice of inunction with refined neat's-foot oil in cases of imperfect general nutrition has been revived by me at the hospital. Contrary to what might be anticipated, it is cleanly, inodorous, and quickly absorbed. Of its usefulness we have had numerous proofs.—*Lancet*, Dec. 30, 1876.

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Femoral Hernia, with a Diverticulum through the Superficial Fascia; Strangulation; Operation; Recovery. (Cooper's Hernia.)—Cases in which the strangulation of intestine or omentum is due to the influence of some band or process of superficial fascia beyond, and external to, any one of the usual tissues forming the wall of the canal, are comparatively rare, and the diagnosis of the actual seat of stricture is thus rendered more difficult.

Mrs. W——, aged fifty-five, was admitted January 4, 1877, into Mr. Bellamy's ward at Charing Cross Hospital, with all the symptoms of strangulated hernia, the reduction of which by the taxis some hours before she came to the hospital had failed. On examination, two large tumours were found in the region of the groin—one external, about as large as an orange, very tense and inflamed, with a slightly ulcerated surface; and a second tumour internal to it, situated above the symphysis pubis, and separated from the former by a deep sulcus (evidently the site of the edge of the vulval aponeurosis), which was thickened and rendered more tough and unyielding by the presence of a cicatrix which was adherent to the subjacent tissues. This cicatrix was the remains of a previous operation for strangulated hernia. Alternate pressure upon the tumours clearly showed them to be connected.

Mr. Bellamy diagnosed a femoral hernia deflected from its usual course, directly over Poupart's ligament, and which had taken a direction upwards and inwards, probably constricted by a fascial band, and evidently strangulated. However, after the amount of taxis which had been applied, he deemed it more judicious to operate at once. Chloroform being administered, he made an incision about three inches long with a bistoury directly through the tough tissues forming the sulcus, down upon the sac, which had the effect of instantly liberating the constriction and of converting the two masses into a single tumour. The inner portion of this consisted of a large knuckle of gut on the verge of strangulation, whilst the external—the one emerging from the saphenous opening—consisted of a coil of gut and a large quantity of omentum, which was highly injected. After gently attempting reduction without success, he divided the sac, from the cavity of which a large quantity of serum escaped; the bowel was then reduced partially, but it was found necessary to nick the edges both of Hey's and Gimbernat's ligaments before both gut and omentum could be entirely replaced within the abdominal cavity. There was no hemorrhage whatever, the external wound was united with a wire stitch, a pad and spica bandage applied, and a full dose of opium administered. The next day she was very comfortable, although there had been a slight attempt at retching, and her evening temperature rose to 101°. On the 7th the temperature was normal, and she passed a natural motion.

She improved from day to day, and is now (Jan. 20th) convalescent.—*Lancet*, February 3, 1877.

MEDICAL NEWS.

ORIGINAL ARTICLES.

Singular Metastatic Action. By WM. BOYS, M.D., of Waverly, Iowa.

I was called the 14th of October, 1872, to see P. J., æt. 19; occupation, farmer. I found a case of parotiditis; both parotid glands were swollen. I saw no more of the patient until nearly two weeks afterwards, when I was called again to see him. I found his left testicle swollen; no enlargement of the parotid glands, and very little constitutional disturbance. Rest and warm-water applications made; oiled silk was prescribed, and within ten days the swelling had almost disappeared.

The same patient, the 25th of June, 1873, while raking hay with a horse-rake was thrown on the treadle, striking his left testicle. It at once became painful, and commenced swelling; no marked constitutional disturbance. A week afterwards it was swollen three times its natural size, and not so painful as at first. I strapped it with adhesive plaster after the method of Fricke, of Hamburg. Within twenty-four hours after the plasters were applied the swelling had apparently left the testicle, and the left parotid gland and surrounding region, which had been up to this time in an apparently normal condition, became enlarged, swollen, and painful—as much so as when he had the mumps. The face remained swollen for a week or ten days.

DOMESTIC INTELLIGENCE.

Prevention of Scarlet Fever.—The Board of Health of Boston has caused a copy of the following circular to be sent to every householder in the city. By a previous circular, physicians are directed to report at once every case of sickness from this cause:—

Scarlet Fever.—The Board of Health issues the following circular of recommendation with the hope that those not familiar with the care of scarlet fever, may be benefited thereby: Scarlet fever is like smallpox in its power to spread readily from person to person. It is highly contagious. The disease shows its first signs in about one week after exposure, as a general rule, and persons who escape the illness during a fortnight after exposure, may feel themselves safe from attack. Scarlet fever, scarlatina, canker rash, and rash fever are names of one and the same dangerous disease. When a case of scarlet fever occurs in any family, the sick person should be placed in a room apart from the other inmates of the house, and should be nursed as far as possible by one person only. The sick-chamber should be well warmed, exposed to sunlight, and well aired. Its furniture should be such as will permit cleasing without injury, and all extra articles, such as window drapery and woollen carpets, should be removed from the room during the sickness. The family should not mingle with other people. Visitors to an infected house should be warned of the presence of a dangerous disease therein, and children, especially, should not be admitted. On recovery the sick person should not mingle with the well until the roughness of the skin, due to the disease, shall have disappeared. A month is considered an average period during which isolation is needed. The clothing, before being worn or used by the patient or the nurse, should be cleansed by boiling for at least one hour, or, if that cannot be done, by free and prolonged exposure to out-door air and sunlight. The walls of the room should be dry-rubbed, and the cloths used for the purpose should be burned without previous shaking. The ceiling should be scraped and whitened; the floor should be washed with soap and water, and carbolic acid may be added to the water—one pint to three or four gallons. The infected clothing should be cleansed by itself, and not sent to the laundry. In case of death from scarlet fever, the funeral services should be strictly private, and the corpse should not be exposed to view. Because children are especially liable to take and spread scarlet fever, and because schools afford a free opportunity for this, the Board of Health has excluded from school every child from any family in which a case of the disease has occurred, and has decreed that the absence shall continue four weeks from the beginning of the attack, except in cases subject to the discretion of the Board, and that the scholar, to be readmitted to his school-room, must have the certificate of a physician that the required time has passed. The proper blanks can be obtained at this office on application.

Infectious Diseases. — The New York Board of Health has issued an order requiring that in the publication of funeral notices the infectious diseases of which patients have died shall be stated.

Medical Society of Virginia.—At the annual meeting of this Society, held at Charlottesville, in October, 1876, the following officers were elected to serve for the ensuing year: President, James L. Cabell, M.D., of University of Virginia. Vice-Presidents, Drs. Christian, of Lynchburg; Figgat, of Christiansburg; Brock, of Richmond; McIlhany, of Warrenton; Stockdell, of Petersburg; and Semple, of Hampton. Secretary, Dr. Landon B. Edwards. The next meeting will be held at Petersburg, on the 23d of October.

Bureau of Medicine and Surgery, U. S. Navy.—Medical Director William Grier has been appointed Surgeon-General of the Navy, *vice* Dr. Joseph Beale, retired.

FOREIGN INTELLIGENCE.

Osteotomy in "Genu Valgum."—At the Congress of Naturalists recently held in Hamburg, an interesting paper on this subject was read in the Surgical Section, by Dr. Max Schede. Antiseptists will be pleased to know that the successful results, to which we will shortly refer, were considered in great measure as due to the antiseptic precautions and dressings which were adopted in the cases. Dr. Max Schede presented to the Congress a young man on whom he had performed cuneiform osteotomy of both tibiæ and both fibulæ. The man had been the subject of exaggerated *genu valgum*, which had resisted all previous treatment. The legs and thighs were at an angle of about eighty degrees. Antiseptic precautions were adopted at the operation (which was done in February), and Esmarch's bandage was applied. A wedge-shaped piece of bone, three-quarters of an inch wide, was excised from each tibia, and the fibula was cut across; the legs were then straightened. At the end of May, consolidation was complete, and the operation thoroughly successful. At the same time he reported other cases where the operation had been done with similar success either for rickets or knock-knees. He mentioned one case in which the tibia had been divided but not the fibula, but the cure was not so complete as in those cases where both bones had been cut. Mr. Howard Marsh recently read before the Royal Medical and Chirurgical Society a paper on Osteotomy of the Tibia for Deformities caused by Rickets; he referred to some successful cases in which he had performed this operation at the Children's Hospital in Great Ormond Street. When we consider how helpless the subjects of extensive rickets and severe knock-knees may become, it is a matter for congratulation to think that surgeons are now able to tackle these diseases with such good chances of success, and with so little risk to the patients.—*Med. Times and Gaz.*, Jan. 6, 1877.

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Wound of the Hand.—Herr **Bardeleben** describes (London *Med. Record*, Dec. 15, 1876) the case of a woman who had been wounded by a sharp hatchet during a quarrel with her husband. On her admission into the Charité Hospital, she had a gaping wound on the forehead, reaching to the bone; and there were numerous wounds on both hands, especially the right. The metacarpal bone of the thumb was cut through, and many of the carpal and carpo-metacarpal articulations were laid open, and several tendons were divided. When Herr Bardeleben saw the patient, every preparation had been made for amputation; but he determined to trust to antiseptic dressings, and to endeavour to preserve the hand. The result was that recovery took place with a very useful hand; the fingers retaining a considerable amount of mobility in spite of the injury of the tendons. No sutures were applied to these.

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Fissure of the Anus.—In place of sudden dilatation or complete incision, Prof. **Gosselin** (*Union Med.*, Jan. 16, 1877) combines the two methods in part. He introduces the index finger every day into the anus, until he is able to see the upper part of the fissure. He next incises this, but only dividing about a fourth of the sphincter ani. He then introduces daily a tent smeared with cerate of extract of rhatany. This method has proved very successful in his hands.—*Med. Times and Gaz.*, Jan. 27, 1877.

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Preliminary Injections of Morphia in Paracentesis Thoracis.—M. **Vibert** (*Journ. de Thérap*, Dec. 25), as the result of several cases in which he has tried it, states that the advantages of the preliminary injection of morphia in the operation of thoracentesis, and indeed in any operation which may give rise to syncope, may be thus summed up: 1. It very much mitigates the suffering inherent to the operation. 2. It protects those operated upon from syncope, and its redoubtable consequences. 3. It obtains for them a sense of comfort, which is produced as soon as the operation is finished, which persists for many hours, and which may be prolonged by additional injections.—*Med. Times and Gaz.*, Jan. 27, 1877.

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Subcutaneous Injections of Cold Water in Acute Rheumatism.—Dr. **Dieulafoy** (*Gaz. des Hôp.*, No. 99) has for several years past been in the habit, in acute articular rheumatism, of injecting some ten drops of cold water around different parts of the affected joint as a means of relieving the pain. The results are most remarkable. The pains abate, and the patient is enabled to move the joint; and in some cases the rheumatism is even cured by this simple means. The same means may be employed also in muscular rheumatism, ischias, etc.—*Med. Times and Gaz.*, Jan. 27, 1877.

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Ammoniacal Tincture of Musk.—Prof. **Lebert** recommends the following formula in cases in which inflammatory affections take on a typhoid or adynamic character: Musk one, carbonate of ammonia one, distilled water ten, and rectified alcohol thirty parts; essence of mint two drops. Twenty-five or thirty drops in water or wine.—*Med. Times and Gaz.*, Jan. 20, 1877.

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Ossification of Artery after Injury.—Mr. Howse exhibited to the Pathological Society of London (*Med. Times and Gazette,* Dec. 23, 1876), a specimen of a rare condition of the wall of an artery, namely, the true ossification. A man of thirty-nine was admitted into Guy's Hospital after having been pitched from his cart, dragged some distance, and finally run over by a cab. The wheel had gone across the shoulder; and a purple tumour, as large as an orange, was found in the axilla, immediately after admission. It was non-pulsating; but no pulse could be felt below the axillary artery, and the hand was cold. Two of the fingers were crushed, but none of the bones otherwise were broken. The treatment was expectant. The patient made excellent progress for some days; warmth returned slowly to the hand, but for a time no sensibility. On the tenth day there was sensibility in the region corresponding to the ulnar nerve. For fourteen days the temperature continued nearly normal; thereafter it rose sharply, and the two crushed fingers were amputated. But on the sixteenth day pyrexia returned, with squint and anomalous brain-symptoms and basic pneumonia. The state was supposed to be one of septicæmia; and, the brain symptoms increasing, the patient died on the eighteenth day. Post-mortem, no septicæmic appearances were found in the lungs—only slight consolidation at one base. The axillary artery, if not torn across, had been greatly contracted in its third portion, and in the external (?) coat true bone was found. The exhibitor said that well-marked cases of ossification of the coats of arteries were very rare, most being mere calcification; although ossification had been described in the walls of aneurism. Callus, too, had been found on the walls of vessels, probably by transplantation of periosteum; but no such explanation could be offered here, as the bones were found entire and covered by continuous periosteum.

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New Anæsthetic Agent.—Rabuteau, in a memoir read before the Académie des Sciences, states that he has investigated the physiological properties and mode of elimination of hydrobromic ether. He has satisfied himself that this anæsthetic agent, which possesses properties intermediate to those of chloroform, bromoform, and ether, might be advantageously employed to produce surgical anæsthesia. The hydrobromic ether is neither a caustic nor an irritant. It can be ingested without difficulty; and applied without danger, not only to the skin, but to the external auditory meatus and to the mucous membrane. It is eliminated completely, or almost completely, by the respiratory passages, in whatever way it may have been introduced into the system.—*Lancet,* Jan. 27, 1877.

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The Force of Example.—A curious instance of the power of the imitative faculty was reported to the Société de Biologie at Paris on November 22, 1876, by Dr. Magnan. At a girls' school near Paris, numbering 115 scholars, a girl, ten years old, was attacked with convulsions in one forearm on July 15, 1876. These convulsions gradually extended in the next few months to all the extremities, and were followed by strong tonic contractions of the muscles, but the child ultimately recovered. Up to November 19, *nineteen* other girls of different ages became subject to exactly similar attacks. They all finally recovered, and the average duration of the disease was shorter than in the original case.—*Med. Times and Gaz.*, Jan. 27, 1877.

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Professional Opinion on Proprietary Dispensaries.—A meeting of the medical profession in London was held on the 4th of December, at the rooms of the Medical Society of London, to discuss the question of proprietary dispensaries. Dr. R. Quain presided. In opening the proceedings, Dr. Quain referred to the difference between proprietary dispensaries (in which it was the object of the owner to make as large a profit as possible out of the patients), and provident dispensaries (which were under the direction of governors, and which might be truly classed among charitable institutions). A proprietary dispensary under the mask of a provident institution was but a prostitution of the name of charity. The following resolution, proposed by Mr. Adams, seconded by Mr. Mac Cormac, was carried unanimously, viz.: "That the principle of establishing proprietary dispensaries under the guise of provident institutions is in the highest degree objectionable, and ought to be discouraged as fraught with danger to the public, and as tending to degrade the status of the profession."—*Med. Times and Gaz.*, Dec. 9, 1876.

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A New Galvanic Battery.—M. LECLANCHÉ has just constructed a new galvanic battery, which the *Annales Industrielles* thinks likely to render great service both in manufactures and in scientific research. The original oxide of manganese battery by the same inventor consists of a porous jar filled with pyrolusite, in which is contained the carbon forming the positive pole. This jar is immersed in a solution of sal-ammoniac in contact with zinc. M. Leclanché has, however, introduced several improvements into this battery. He has superseded the porous jar by conglomerating the oxide of manganese, mixed in nearly equal parts with carbon, but with the addition of a small quantity—5 per cent.—of resin for the purpose of giving consistency to the mass. These three substances, properly pulverized and intimately mixed, are conglomerated under a considerable pressure, and at a temperature of about 100° Cent. (212° Fahr.) into a solid cylinder, which serves at the same time as a porous diaphragm and a positive electrode. But here a difficulty occurred. Under the influence of the current, an almost insoluble oxychlorate of zinc was formed, which was deposited in a crystalline form in the pores of the electrode, and considerably diminished its conductibility, so that the internal resistance of the battery increased very rapidly, occasioning considerable inconvenience, especially when used for telegraphic purposes. M. Leclanché has now got rid of the difficulty by inserting in the centre of the carbon and manganese electrode, while being moulded, a small cylinder of bisulphate of soda. This acid salt prevents the formation of the oxychlorate of zinc; and the battery preserves its regularity for more than a year without the necessity for renewing the water of the saline solution. It offers a much slighter resistance than other batteries, and gives out a considerable quantity of electricity. A single element of small size, presented by M. du Moncel to the Académie, immediately caused a platinum wire connecting its two poles to become red-hot.—*London Med. Record*, Nov. 15, 1876.

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International Medical Congress, Philadelphia, 1876.—At the meeting of the Obstetrical Society of London, held on Jan. 3d, the report of the delegate to the International Medical Congress was read by Dr. ROBERT BARNES, the delegate representing the Society at the Congress. Dr. Barnes, who was elected President of the Obstetric Section, expressed his high estimation of the papers read before the Section, and his great admiration for the zeal and earnestness with which work was done. He gave a brief sketch of the manner in which the business of the Section was conducted, and concluded by expressing his gratification at the hospitality and kindness shown him in America.—*Lancet*, Jan. 20, 1877.

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Pathological Society of London.—We are glad to learn that the Council of this Society have decided to apply to the Government Scientific Grant Committee for a grant of money, to enable a committee of the Society to undertake an organized investigation of the intimate pathology of the morbid processes commonly designated pyæmia, septicæmia, and purulent infection, having special reference to their various causes. Should the scheme be carried out, we may anticipate results of the highest practical importance.

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SUMMARY OF CONTENTS.

CHAPTER I. INTRODUCTION. II. Assimilation. III. Excretion. IV. Body Heat and Fever. V. Inflammation: its Varieties. VI. Anæmia; Plethora; Congestion. VII. Growth and Decay. VIII. Abnormal Growths. IX. Blood Poisons; Specific Poisons. X. Acute and Chronic Disease. XI. Diabetes; Rheumatism, Gout. XII. Diatheses and Cachexiæ. XIII. Action and Inaction. XIV. The Circulatory System. XV. The Respiratory System. XVI. The Digestive System. XVII. The Urinary System. XVIII. The Reproductive System. XIX. The Cutaneous System. XX. The Lymphatic System. XXI. The Nervous System. XXII. Public and Private Hygiene. XXIII. Food in Health and Ill-Health. XXIV. Conclusion—The Medical Man at the Bedside.—APPENDIX: Salicylic Acid; Jaborandi; Hydrobromic Acid. INDEX.

It will be seen from this that the scope of this work is not dissimilar to the well-known "Principles of Medicine," by Dr. J. C. B. Williams, now long out of print, which in its day met with such unusual acceptance. More practical in its character, however, it seeks to bring to the aid and elucidation of positive therapeutics, the vast accumulation of scientific facts and theories made by the present generation, pointing out the measures to be adopted at the bedside, and establishing them on firm rational grounds. Such a work, by a first-rate man, and fully up to the advanced condition of science, cannot fail to prove of the utmost service to both student and practitioner.

It is our honest conviction, after a careful perusal of this goodly octavo, that it represents a great amount of earnest thought and painstaking work, and is therefore one of those books which both deserve and are likely to survive. This book, although written ostensibly for the young and inexperienced, may be very profitably studied by those who have been practising their profession, more or less empirically, for thirty or forty years. We particularly commend the chapters on Public and Private Hygiene, Food in Health and Ill-Health, and the Conclusion—the Medical Man at the Bedside. The last is high-toned and indicates much shrewdness of observation. Our space will not admit of further quotation. We content ourselves with again recommending the book very cordially.—*Edin. Med. Journ.*, Jan. 1877.

It is of great advantage to the practitioner to have general principles to guide him, and that he should not, when confronted with an assemblage of pathological symptoms, be at the mercy of an unreasoned experience of a similar case, or be obliged to swear *in verba magistri*. He will find reasons in this work for not looking upon drugs, as grouped in fixed and unalterable categories, but learn when and why he may give opium to cause purgation, and castor oil to check it. We strongly commend it to our readers.—*The London Practitioner*, Jan. 1877.

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We are very much pleased with Mr. Schafer's book. It is clearly written, well and originally illustrated, and possesses the merit of being both concise and complete. In conclusion, we may say that any student who has gone fairly over the ground covered by this treatise, will find that he has not only gained a mastery over the modern methods of microscopical investigation, but a sound knowledge of the several structures of which the body is composed.—*Lond. Lancet*, Jan. 2, 1877.

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CLINICS.

CLINICAL LECTURES.

On Syphilitic Epilepsy. By M. CHARCOT, Professor of Pathology at the Faculty of Medicine, Paris, etc.

Partial or hemiplegic epilepsy is one of the most frequent affections attendant on cerebral syphilis. I have recently had an opportunity of treating several cases, and shall proceed to point out some special features connected with this form of the disease, and the rapid manner in which the bold administration of certain remedies will frequently triumph over it. The following case may serve as an introduction to my remarks:—

On the 13th December, 1874, I was called in consultation to visit a gentleman, æt. 42. For several months he had laboured under a serious cerebral affection, which confined him to his bedroom. The patient counted the date of attack from the month of July, 1874. One day, while sitting at his desk, and without any premonitory symptoms whatsoever, he was seized with violent convulsive movements in the right leg. They lasted for a very brief time; the limb then became rigid, was elevated for a moment, and the patient fell unconscious on the floor. The attack was not repeated, and the patient was able to resume his duties as a banker's clerk. In the month of September following, while getting off an omnibus, he had a second attack, precisely similar to

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the former one, but the effects were more lasting, slight weakness of the right side and considerable confusion of the intellectual faculties remaining. The third attack took place in November of the same year. On this occasion the prodromata were of longer duration, and the patient was enabled to observe that the convulsive movements, followed by rigidity, commenced in the leg, and very soon afterwards extended to the arm. He soon fell insensible to the ground, but a bystander observed that the head was drawn to the right side, that the face on the same side was spasmodically affected, and that the whole right side of the body became finally convulsed. This access was attended by stertorous breathing; some disturbance of articulation and a sense of numbness in the right cheek ; the last two remained for a few days, and then subsided.

The history of the case pointed towards syphilis, but no actual syphilitic lesion was discoverable. On going back further, however, some light was obtained. When 30 years of age the man had contracted indurated chancre, followed by roseola and other constitutional symptoms. He underwent the usual treatment for several months, and seemed to have been radically cured, as no recurrence had taken place during a period of ten years. Towards the end of 1873 the general health gave way. The patient fell into a state of cachexia, attended by a peculiar kind of headache. The pain was at first confined to a very limited spot on the temple, above the right eyebrow. It often extended, by nocturnal exacerbations, to the head and occiput.

This peculiar form of headache is especially worthy of note, as it has frequently been noticed by writers on syphilitic epilepsy.

My opinion as to the nature of the case was soon formed, and I recommended what we call the mixed course, viz., mercury and iodide. It appeared, however, that the patient had been submitted to the same treatment for the last twelve months, without permanent benefit. I was not discouraged on learning this, but concluded that we must make a more vigorous attack by giving large doses of the remedy at short intervals. In two months great relief was obtained by mitigation of the leading symptoms, viz., headache, dyspepsia, and weakness of the limbs, while the epileptic attacks had ceased. The patient considered himself free from the disease. I saw him again at the end of 1876. Relapse had not taken place, and the patient, in outward appearance at least, seemed perfectly well.

Partial epilepsy, whether of syphilitic origin or not, generally commences by convulsive movements of the face or arms on one side of the body. An attack commencing in the lower extremity must, therefore, be regarded as exceptional. In some cases, moreover, the disease assumes the appearance of ordinary epilepsy, for the patient suddenly falls down in an unconscious state, followed by convulsions, which are more or less general in character. The imminence of the latter is constantly indicated by severe headache, confined to a limited spot on the side of the head. The pain quickly extends to the face and neck on the same side; but there are exceptions to this general rule, for in several cases I have observed that the premonitory headache occupied two points at the same time, one on the parietal, the other on the temporal region of the opposite side. In these cases the parietal pain was always seated on the side opposite to that of the convulsive movements. Another point to be noted is that the attacks very frequently set in towards evening. The manner of attack, and the succession of convulsive symptoms, are conformable to the rules established by Dr. Hughlings Jackson. That distinguished physician has observed that when the convulsive movements of partial epilepsy, commencing in the arm, tend to become more general, they attack the face before they extend to the leg. If the irregular movements have commenced in the face, the disease extends to the upper extremity first, and then to the legs. Lastly, if it be the lower extremity which is first attacked, the disorder of motor power is seen in the arm first, and then in the face. This constancy in the order of succession is very remarkable, and appears to me calculated to throw light on various questions connected with physiology of disease.

Another point, illustrated by several of my cases, is this: The premonitory headache often occupies a circumscribed spot on one side of the head, while the convulsive movements appear on the other side of the body. This clinical fact is interesting, as it points to a relation between cause and effect; for we know that the cerebral surface which lies beneath the parietal bone, and especially the convolutions bounding the fissure of Rolando (the ascending parietal and frontal convolutions) constitute the motor zone which alone acts on the opposite side of the body, and when irritated produces a disturbance of motor power similar to that seen in partial epilepsy.

Circumscribed gummatous inflammation of the pia mater appears to be the pathological condition most frequently connected with partial syphilitic epilepsy. This has been pointed out by Todd, Echeverria, Lancereaux, and some other writers. It is, however, certain that several other forms of cerebral disease may be determined by this same gummatous meningitis. The variations, as we have good reason to believe, depend on the points of cerebral surface attacked. If we accept the theory founded on recent investigations, the gummatous patches in partial syphilitic epilepsy should be found on, or very near to, the ascending frontal or parietal convolutions. This has not yet been established by actual observation, but I feel confident that the proof is only delayed. So long as the disease has not become inveterate—so long, in a word, as there are intervals of freedom from attack, we are entitled to conclude that the cerebral substance had not been disorganized by the gummatous inflammation of the meninges. Upon this point and its clinical interpretation Dr. Hughlings Jackson has formed a very ingenious theory. To return, however, to therapeutical conclusions, I would insist on the necessity of having early recourse to energetic treatment in all cases of this kind, and not waiting until extension of the superficial lesions has involved the deeper layers of the cerebral substance, for then secondary descending alteration of nerve-tissue will ensue, and the probable consequence will be irremediable and permanent hemiplegia.—*Medical Examiner*, March 8, 1877.

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Epilepsy and Epileptic Vertigo.—Prof. Bouchut recently gave a clinical lecture on two cases of epilepsy (*Gaz. des Hôp.*, January 23 and 25) at the Hôpital des Enfants Malades, of which the following is an abstract:—

Epilepsy in children is of very frequent occurrence, and differs greatly both in its etiology and prognosis from epilepsy in adults. It shows itself in two forms—epileptic vertigo (or *petit mal*), and epileptic convulsion (or *haut mal*). Of the 118 cases which Prof. Bouchut has met with, thirty-six were examples of epileptic vertigo, and eighty-two of epileptic convulsion. *Epileptic vertigo* presents itself under the most varied forms. Always of short duration, there is a fugitive loss of consciousness of a few seconds or a minute, during which the face preserves its colour, the eyes are fixed and turned upwards, and the head is immovable, being sometimes thrown backwards or turned to the right. The arms cease to act without becoming convulsed or rigid, and the lower limbs are immovable. If the child is sitting, he does not move beyond bending forwards or on one side, and then recovering the vertical position, like one asleep while sitting. If standing, he may bend and recover himself in the same way, or remain motionless. Sometimes speech is cut short by the crisis, and is resumed after the interruption. In rare cases there is emission of the feces or urine. These vertigos, rare at first, become more and more frequent, and are often unperceived by reason of their short duration or of their occurring at night. They may occur only every month, fortnight, every day, or very many times in a day, so that in one case 180 were counted in one day. These crises may last for several months in this form, infinitely varied, and then pass into the regular epileptic convulsion. In other cases they cease spontaneously or yield to treatment.

Convulsive epilepsy is characterized by sudden and violent convulsive paroxysms, or may be preceded by premonitory symptoms known as the *aura*. Numerous well-marked instances of this aura arising at the extremities are on record, which also show the influence of its destruction on the cure of the epilepsy, and the possibility of arresting a paroxysm by a ligature or forcible compression applied in the track of the aura. When this premonitory symptom does not exist, the instantaneousness of the attack is characteristic. There may be pallor of the face with blanched lips, or this may be red or violaceous, with black lips and swollen neck. To the ophthalmoscope the fundus of the eye is pale in the one case, while in the other its veins are very red and very dilated. The convulsive paroxysm may only last for some minutes, or, subsiding for a moment, it may recommence and thus continue for one or several hours. When a calm has at last become established, the child falls into a more or less comatose sleep, which lasts from one to three hours, awakening with a sense of excessive fatigue. It is rare for these epileptic paroxysms to recur several times in a day, and they usually reappear at irregular epochs; and when they do exceptionally occur periodically, this is especially in girls arrived at the age of puberty and at the menstrual period.

The diagnosis of epileptic vertigo is easy, but the convulsive form may be often confounded with eclampsia, and in girls, with hystero-epilepsy. The mere accidents of the attack do not enable us to distinguish *eclampsia* from epilepsy, our diagnosis being derived from the accessory circumstances of the onset and the return of the convulsions. When the convulsion comes on suddenly and is followed by fever, it is eclampsia, and is the indication of a pneumonia, angina, eruptive fever, or other acute malady. When albuminuric œdema is present, it is also eclampsia, due rather to cerebral œdema than to uræmia. So also when the convulsion is the result of heat, the overcrowding of children, or indigestible aliments, it is due to eclampsia; as it is when it comes on without known cause, in a passing manner and without ulterior repetition. So similar are the intrinsic phenomena of the two diseases, that eclampsia might almost be termed a fugitive epilepsy. In distinguishing *hysteria* from epilepsy, the form of the convulsive accidents has to be taken more into account. Thus, when the loss of consciousness is not very complete, when there is some amount of recollection, and when the attack is announced by some intimate sensation other than aura, and is accompanied or followed by a sense of choking, and cries and laughter, with analgesia or cutaneous anæsthesia, it is hysteria; but when, as in some cases, there is absolute loss of consciousness, without tears or laughter, and profound sleep after the attack, it is hystero-epilepsy. This form is not very frequent in children, and affects chiefly girls after their twelfth year. One point is always a difficult one in the diagnosis of epilepsy —the decision as to whether the disease is essential (*i. e.*, caused by a temporary disturbance of the cerebro-spinal circulation), or whether it is symptomatic of an organic nervous lesion. This difficulty has, however, almost ceased to be one since Prof. Bouchut's researches in cerebroscopy, which are described at length in his recently published *Atlas d'Ophthalmoscopie Médicale et de Cérébroscopie.* If with the convulsions there is papillary œdema, with hyperæmia, neuro-retinitis, or tubercles of the choroid, the epilepsy is certainly dependent upon a cerebral or spinal sclerosis, a partial encephalitis, or some deposit in the nervous substance. If there is no changed condition found in the fundus of the eye, we may believe (without, however, being quite certain) that the epilepsy will only prove temporary.

After a disquisition on the reflex and direct causes of epilepsy, for which we have not space, Prof. Bouchut passes to the prognosis, which he observes is very different in children and adults. Before the age of fifteen epilepsy is generally curable; and the aphorism of Hippocrates, that the epilepsy of childhood is cured after puberty, is entirely true. That it is so probably arises from the fact that the majority of such epilepsies have their origin in the second dentition, when the teeth of a man are placed in the jaws of a child. After puberty they more easily assume their proper places, and the epilepsy ceases with the reflex action which produced it. Epilepsy from direct causes, as from sclerosis or other cerebral or spinal lesion, however, calls for a very different prognosis from those of reflex origin, for although they are sometimes ameliorated they are rarely cured.

In the treatment of epilepsy, wherever there is an aura we should endeavour to destroy it, as arrest of the attacks has been proved to follow the disappearance of this peripheral neuralgia. Thus, deep cauterization in neuralgia of a branch of the intercostal nerve cured the epilepsy in two cases. When the epilepsy is dependent on worms, appropriate vermifuges must be had recourse to: and the dyspepsia with which it is sometimes connected in children should be met by a vegetable and milk regimen, pepsin, small doses of bicarbonate of soda, the waters of Plombières, etc. In irregular second dentition, the removal of teeth which are too long in falling is often attended with advantage. Besides the rational treatment of causes, we may have recourse to antispasmodics which regulate the movements of the capillary circulation, such as belladonna, bromide of potassium, oxide of zinc, ether, chloroform, etc.; but of all these none possesses the same efficacy as the bromide. It may be given united with belladonna in the following formula, but it is upon the bromide that we should chiefly rely; Simple syrup 240, syrup of belladonna 60, and bromide of potassium 20 parts; of this doses of one gramme may be given two, three, four, and even to six times in the day, according to the case. The bromide does not in children produce the ill effects which it sometimes does in the adult, only accidents that have been observed, even in doses of six, eight, or ten grammes per diem, prolonged for some time, being stupor and hebetude, which disappear on diminishing the dose. If it be given in reflex epilepsy, in progressive doses of three or four grammes to children from five to nine years, and of from four to ten grammes to children of ten to fourteen, most of the cases will be cured. When the epilepsy arises from an organic cause, the most that can be done is to render the attacks less frequent. The application of cold externally by means of frequent douches is a useful auxiliary, tending by the cutaneous revulsion it induces to restore the equilibrium of the capillary circulation.—*Med. Times and Gaz.*, March 3, 1877.

HOSPITAL NOTES AND GLEANINGS.

Case of Intussusception successfully treated by Inflation.—On Dec. 14th, a male child, aged six months, was taken to the North Dispensary, Liverpool, and placed under the care of Mr. T. D. Ransford. Just before six o'clock on the previous evening the mother was dandling the child (which seemed at the time quite well and in good spirits, and had not presented any signs of diarrhœa or intestinal disturbance) on her knee. Quite suddenly the baby became pale and seemed in great pain, and broke out into a cold, clammy sweat. At half-past six it passed a blood-stained motion. All night the child was very restless, and got no sleep until 2 o'clock in the morning; it then slept one hour, and then passed blood again, while vomiting had been almost constant from the beginning.

When seen at the dispensary, the child seemed to suffer much from paroxysms of pain, during which he cried out and was very restless; the abdomen was flaccid and not painful on pressure, and an indistinct rounded mass was felt in the left hypochondriac region. He was taken to the Northern Hospital to be treated as an in-patient, but the mother would not consent. Here he was again examined, and as no other abdominal tumour could now be felt, and a rectal examination elicited very different opinions, the diagnosis of intussusception was considered doubtful. Nevertheless an injection of olive oil was tried; this was followed by no other effect than the passage of some clotted blood. The child was then sent home, where it was seen shortly afterwards, and a drop and a quarter of tincture of opium given every six hours.

The child passed a tolerable night up to two o'clock, and passed no more blood; but next day the vomiting and pain continued unabated, and the obstruction seemed to be quite complete. Temperature in rectum 100.4°; pulse 136. At 3.30 P. M. the rectum was examined and found empty, but when the child strained something was felt to impinge upon the finger. The finger was stained with blood and mucus, but there was no trace of feces. Although the child had not vomited since the morning, vomiting occurred during the rectal examination. With the assistance of Dr. Cormac, inflation by bellows was practised for about twenty minutes, some air escaping per anum at each action of the bellows. The child passed about a tablespoonful of blood and mucus when the nozzle of the bellows was withdrawn.

Dec. 16.—The mother states that since the inflation the child has been easier, the vomiting has not returned and at five o'clock this morning he passed a liquid motion free from blood. Flatus has been passed in abundance, and he has had a good night. Child seems nearly free from pain. On digital examination, the rectum offered nothing abnormal, but was found full of feces, which passed in abundance on withdrawing the finger. Takes the breast well. Temperature in rectum 100.2°; pulse 128. For a day or two the opium was continued, with the object of keeping the bowels quiet and of relieving pain, for which hot fomentations were also applied. By the end of the second day everything was left off, and when the child was seen for the last time, on the 22d of December, the mother said he was well as ever, with the exception of being a little pale.

Remarks.—In this case the diagnosis of intussusception was doubted by some, because no abdominal tumour was felt; but West says " it happens in at least a large number of instances that the most careful examination fails to detect anything unnatural." It was also said that the absence of abdominal tenderness contraindicated intussusception; but Bristowe says there is "not necessarily any abdominal tenderness—indeed the patient often finds relief, as in colic, from pressure on the abdominal parietes." But the sudden attack in a previously healthy child seems diagnostic. Nothing else than intussusception could bring on total and sudden obstruction of the bowels, with early passage of blood and paroxysmal pain, in a baby six months old.

As to the treatment, every one will agree that an attempt to reduce the intussusception, either by inflation, or injection, or position, is to be made before other chances are taken into consideration; but, if these fail, is it justifiable to urge abdominal section? In this case the mother was told that if the bowel could not be got back, an operation might be necessary, but that it could not be said that the child was certain to die if it were not done; for although Hutchinson has stated that in cases of intussusception of the large intestine he had never seen a recovery take place, yet Bristowe states that " the results of the separation of the slough seem favourable in about half the total number of cases;" and as to the published statistics of the operation, they are very little to be trusted, for all the successful cases are certain to be published, while many of the unsuccessful cases are not. In a review of the subject, in the *Lancet*, some months since, eighteen cases are said to have been recorded, with eight recoveries. One thing seems certain, that unless an operation is done early in the acute cases, it is better to trust to cure by the bowel sloughing, for in one case of abdominal section which Mr. Ransford saw in a child, the intussusception could not be reduced, and the operation did no good. In the chronic cases death seems to take place from exhaustion, often before any inflammation or sloughing has taken place; and in this class no doubt abdominal section gives a very fair chance of recovery a long time after the symptoms have set in, as the cases of Messrs. Hutchinson, Marsh, and Howse prove.—*Lancet*, Feb. 24, 1877.

Chorea treated by Strychnia and Ether-Spray.—Dr. J. Magee Finny reported to the Medical Society of the College of Physicians of Ireland (*British Med. Journal*, Jan. 6, 1877) four cases treated by these means. Case I. was one of severe chorea in a boy aged 13, without any history of rheumatism or of cardiac disease. The treatment by sulphate of strychnia, administered as recommended by Hammond (*Diseases of the Nervous System*, sixth edition, page 720), and by ether-spray along the back, was commenced a fortnight after the illness began. Immediate benefit was followed by recovery in fifteen days. The total duration of illness was, therefore, four weeks and one day. Case II. was one of severe primary bilateral chorea in a girl aged 11, without history of rheumatism or of cardiac disease. Improvement set in after four days' treatment; cure was complete in twenty-five days. The total duration of illness was six weeks and three days. Case III. was one of severe primary bilateral chorea in a boy aged 9; no rheumatism or cardiac complication. Improvement took place, but he left hospital before he was cured. Case IV. was one of chronic chorea, with relapses, in a young lady aged 15. The treatment led to considerable improvement in a week. The treatment of chorea ought to fulfil two indications: to shorten its duration, and to temper and moderate the more distressing symptoms; and, should it fulfil these, it deserves to be valued as useful. Reviewing the foregoing cases, the author would say of strychnia that, in the two cases in which its administration was fully and regularly carried out, it fulfilled the first indication by shortening the disease, and in those cases it rapidly alleviated the symptoms and quieted the movements. As far, therefore, as these cases go, strychnia proved to be well suited and the proper treatment. To come to any definite general conclusion on such a subject, without much and extended observation, would be in the highest degree reprehensible; but it is also the more the duty of each clinical observer to record the results of his experience.

Dr. MacSwiney referred to recent theories as to the pathology of chorea. Dr. Dickinson found in twenty-two fatal cases that there was universally present a dilated condition of the bloodvessels of the brain and spinal cord, and in many cases effusion of blood into the brain and spinal cord. The relationship between chorea and rheumatism was very remarkable. If the dilatation theory were correct, the efficacy of the cold of ether-spray and the peculiar therapeutic effect of strychnine could be understood. It had been recently stated that there were grounds for believing that hypermetropia occurred in all cases of chorea, and that the cure of the chorea could be effected by using glasses to correct the hypermetropia.

A Case of Lithotrity where Nitric Acid Injections were employed.—The solvent action of nitric acid upon the *débris* of a phosphatic calculus was well illustrated in the following case, which in many respects is similar to one recorded by the late Mr. Southam, of Manchester, and alluded to by Dr. W. Roberts in his Observations on the Solvent Treatment of Phosphatic Calculi. (*On Urinary and Renal Diseases*, second edition.)

William C., a police officer, aged 45, was admitted into the Liverpool Royal Infirmary, under my care, on March 9th, 1875. The patient had recently been under the observation of my friend Dr. J. S. Clarke, who, having diagnosed the existence of a stone in the bladder, advised his admission into the infirmary.

Upon examination, I found a single stone, rounded and having a diameter of two inches and a quarter. The urine was alkaline, and contained pus. Though the stone was large, I deemed the case not unfavourable for lithotrity. The patient required some preparatory treatment, and I was not able to commence lithotrity till April 5th. I repeated the crushings during April and May twelve times.

The patient never experienced any unfavourable symptom, and a very considerable quantity of broken-up stone was passed. As in Mr. Southam's case, to which I have alluded, it appeared to me that fresh phosphatic depositions were taking place almost as fast as the others were removed. I resolved, therefore, to use nitric acid injections.

On May 27th (two days after a crushing), I had the urine of twenty-four hours' collection. This was analyzed by Dr. J. Campbell Brown, who gave me the following report: The quantity of urine submitted to analysis was sixty ounces; this was found to contain 74.029 grains of phosphoric acid as alkaline earthy phosphates; 250.516 grains of phosphoric acid as alkaline phosphates; in all, 324.545 grains of phosphoric acid passed in twenty-four hours. On the termination of this twenty-four hours, I injected into the bladder half a pint of tepid water with two drachms of diluted nitric acid.

All the urine passed during the subsequent twenty-four hours was kept and analyzed by Dr. Brown, with the following result: The quantity of urine submitted to analysis was seventy-eight ounces; this was found to contain 96.237 grains of phosphoric acid as alkaline earthy phosphates; 461.94 grains of phosphoric acid as alkaline phosphates; total, 558.177 grains of phosphoric acid passed in twenty-four hours.

Thus it appears that not only was a larger quantity of phosphate of lime and magnesia dissolved in the urine after treatment with nitric acid, but there was a still greater increase in the quantity of phosphoric acid passed in the form of alkaline phosphates. It is to be noticed that the quantity of urine on the day after treatment was greater than on the day before; and that, if, instead of estimating the total phosphates, we estimate the percentage of phosphates in the urine, we find that the percentage of alkaline earthy phosphates was very nearly the same after as before treatment, namely, increased from 0.272 to 0.282, and that the percentage of alkaline phosphates was increased from 0.95 to 1.35. But the absolute increase of phosphates is much more marked.

On nine subsequent occasions the lithotrite was employed, and, on every second or third day afterwards, the bladder was injected as before with nitric acid in tepid water. Further observations, though made in a rougher manner, showed the increase of the alkaline phosphates after each injection; it was also noticed that the fragments passed were much more finely triturated than previously.

Under this treatment the patient made a good recovery, and left the infirmary quite well on June 21st. The total quantity of broken-up stone collected weighed four drachms. The use of the acid appeared to me at once to stop any further deposition of phosphates, and to facilitate the removal of the pieces as they were broken up by the lithotrite.

Dr. Roberts concluded his observations on Mr. Southam's case with the remark (*op. cit.*, p. 313): "This method is evidently capable of wider application than is now made of it by surgeons."—*British Med. Journal*, Jan. 6, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Lister's Antiseptic Method.—Dr. J. S. Billings, of the U. S. Army, in a lecture (*Med. Record*, March 3, 1877) delivered in Baltimore shortly after his return from Europe, spoke of the antiseptic method as follows:—

"I was acquainted with Mr. Lister's teachings before visiting Europe, and assented to them in a theoretical sort of way; but at the same time I looked upon the antiseptic method as being the latest fashion, and therefore probably overpraised. But after learning the result of its employment in the hospitals at Bonn, Leipzig, Berlin, and in certain wards in London, and especially after an examination of Mr. Lister's wards in the Royal Infirmary at Edinburgh, and seeing the cases dressed in all stages after operations—operations such as opening the knee-joint, or upon abscesses of spinal origin—I came to the conclusion that this method is the most important contribution to our resources in surgery which has been made since the discovery of anæsthesia. Not that the details of the method are perfected, for probably much may yet be done to simplify it, and we may perhaps discover a better material for the purpose than carbolic acid; but we now may be said to know positively, instead of merely conjecturing, that the process of putrefaction is due to minute solid and semi-solid particles floating in the air, and that Mr. Lister has devised a method by which these particles can either be kept out of a wound made by the surgeon, or by which they will have their power of producing the putrefactive change destroyed, is, I think, beyond doubt.

"The fact that the various changes in organic matter which we know as fermentations, putrefactions, etc., are due to minute organisms, which organisms are not spontaneously developed, but arise from similar organisms only, is one of great importance in hospital management."

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Improved Adhesive Plaster. — With a view to overcome the disadvantages of the common adhesive plaster Dr. MARTIN, of Roxbury, has devised (*Boston Med. and Surgical Journal*, March 8, 1877) an improved plaster composed of India rubber and Burgundy pitch in about equal proportions, a very small amount of some other gum-resins and less essential substances, introduced chiefly for convenience of manipulation. The adhesive compound is spread upon a strong drilling cloth, and presents the following important advantages; it contains no solvent whatever, and hence can be used with impunity upon the most sensitive skin. When brought into apposition with the skin, it adheres at once and at all temperatures, without the application of heat, and instead of losing its hold after a while, it clings with increased tenacity, not becoming detached or loosened, even when the parts around it are bathed with cold or tepid water. This peculiar adhesiveness and the strength of the cloth upon which it is spread constitute its chief advantages. Experiments are being made with a view to applying the adhesive compound to water-proof cloth, applicable to certain surgical exigencies; and if these attempts are successful, the last desideratum will have been met.

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Honours to American Physicians.—At the meeting of the Obstetrical Society of London, held on the 7th of February, Dr. E. R. Peaslee, of New York, was elected Honorary Fellow, and Drs. William Goodell, of Philadelphia, and Horatio R. Storer, of Boston, were elected Corresponding Fellows.

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Medical Graduates in 1876.—

University of Pennsylvania	121
Jefferson Medical College (Phila.)	198
Coll. of Phys. and Surgeons, N. Y.	118
Bellevue Hospital Med. Coll., N. Y.	147
University of the City of New York	157
Rush Medical College, Chicago	103
Missouri Medical College	65
St. Louis Medical College	51
Medical College of Ohio (Cincinnati)	80
Albany Medical College	38
Buffalo Medical College	30
Coll. of Phys. and Surgeons, Ind.	23
Medical College of Indiana	22

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OBITUARY RECORD. — In New York, March 6th, GURDON BUCK, M.D., aged seventy years

Dr. Buck is perhaps best known to the profession by his advocacy of the weight and pulley treatment of fractures of the thigh, and by his contributions to plastic surgery.

—— at Boston, on the 19th of February, aged 56 years, CHARLES E. BUCKINGHAM, M.D., Professor of Obstetrics and Medical Jurisprudence in Harvard University.

FOREIGN INTELLIGENCE.

Relief of Pain by the Outward Application of Hydrate of Chloral.—Dr. W. B. KESTEVEN (*Lancet*, Feb. 10, 1877) calls attention to the benefit to be derived in the relief of pain by the external application of hydrate of chloral, for the knowledge of which he is indebted to his friend Dr. T. S. Dowse, of the Central London Sick Asylum, Highgate. The vast field that is afforded by these metropolitan institutions for the cultivation of practical medicine is not neglected by Dr. Dowse, but is turned by him to good account. The results of the trial of hydrate of chloral as an external application have lately been given. Dr. Kesteven adds his experience of this mode of using this drug, in order that it may become more widely known.

He has tried it with great success in neuralgic pains and in cancer of the breast, in cases in which other sedatives and narcotics have failed to give relief.

The mode of application is by the saturation of folds of lint of the size of the part to which it is to be used, brought into close contact, then covered with three or four layers of lint covered with oil-silk or spongio-piline wrung out of hot water. The application to raw surfaces, of course, requires some care in manipulation.

The strength of the solution is about four drachms to sixteen ounces of water. The addition of a small quantity of glycerine is advantageous. Chloride of zinc or perchloride of iron can be combined with the chloral in certain cases.

Salicylic Acid.—M. A. Robin asserts, in a communication to the Biological Society of Paris, that, in typhoid fever, salicylic acid almost constantly diminishes the quantity of urine excreted, and the quantity of indican increases under its use; moreover, it produces ulceration of the back of the throat, and even consecutive œdematous inflammation of the larynx. He recommends very dilute solutions in typhoid fever, for fear of arresting the flow of urine. He had observed a buzzing in the ears as the result of the use of salicylic acid. M. Leven is opposed to the use of this substance in typhoid fever. Powerless in small doses, it causes serious troubles in the digestive system, which are especially dangerous in that disease. M. Lepine finds, also, that the acid is very slightly excreted in typhoid, and that it produces a buzzing in the ears, but less intensely and less constantly than with quinine. Valuable in some cases of acute rheumatism, it renders no service in typhoid fever.—*British Med. Journal*, Feb. 10, 1877.

Cantharidian Cystitis.—Under this title Dr. Vézien gives (*Rev. Médicale*, Feb. 12) an account in the *Journal de Pharmacie d'Alger* of an affection of the genito-urinary organs, which he says the military surgeons are familiar with among the soldiers in Algeria. It has been commonly termed by them urethritis, but it is really a cantharidian cystitis, easily recognizable by its symptoms. Its origin is a curious one, it being produced by eating the flesh of frogs, which in the months of May and June feed almost exclusively upon vesicant insects belonging to the tribe of cantharides. The irritating properties of these coleoptera are found in the flesh of the frog, which in a certain number of instances produces this affection in those who partake of this food.—*Med. Times and Gaz.*, March 3, 1877.

Scrofulous Ulcers: Red-Lead and Cinnabar Plaster.—In his wards at the hospital of Saint-Louis, M. Vidal has for several years made use of a plaster which he considers very afficacious in cleansing the greater number of ulcers and scrofulous sores. Its composition is as follows: Diachylon plaster, 26 parts; red-lead, 2.50 parts; cinnabar, 1.50 parts.

These ingredients are thoroughly mixed and spread upon a piece of calico like an ordinary diachylon plaster; small pieces of the plaster are used a little larger than is sufficient to cover the ulcer. It is a very appropriate mode of treatment, and may be easily employed for a long time. M. Vidal recommends it strongly.—*London Med. Record*, Feb. 15, 1877.

Ovariotomy at the Samaritan Hospital.—The year 1876 has been the most successful on record at the Free Samaritan Hospital—the operation of ovariotomy having been performed fifty-five times with only five deaths. Forty of these were performed by Mr. Spencer Wells, with four deaths; seven by Mr. Bantock, with one death; and eight by Mr. Knowsley Thornton, without a death. The fifty-five cases include many in which both ovaries were found diseased and removed; and many of the operations were most formidable from the nature and extent of the adhesions. No case in which the diagnosis of ovarian tumour was made was refused the operation, however bad the prognosis, provided the patient still wished to have the last chance when the extra danger of her case had been fully explained to her. We believe these are the best results yet published, either in hospital or private practice; and if there are any members of the profession who still have doubts as to the advisability of ovariotomy, we commend these cases to their consideration.—*Med. Times and Gaz.*, Feb. 17, 1877.

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The Protective Results of Revaccination.—The following facts should be considered sufficient to establish the importance of revaccination in the minds of those few who may still have any lurking doubts on the subject. Dr. GAYTON, Medical Superintendent of the Smallpox Hospital at Homerton, reports under date January 30 last: "During the present epidemic, fifty-six fresh servants have been engaged here; of these, twenty-seven had previously suffered from smallpox, and twenty-eight were revaccinated on taking office. One who was, unfortunately, not reported to me, and who had neither been vaccinated since infancy nor previously had smallpox, speedily contracted it. With this exception, our staff has enjoyed perfect immunity." Dr. COLLIE, Medical Superintendent of the Fever Hospital at Homerton (now devoted to smallpox patients), says, in his report dated January 31 last: "About twenty-five persons in the service of this Asylum have been revaccinated during the present epidemic. None of these have contracted smallpox." This recent testimony confirms the report which was presented by a committee to the Metropolitan District Asylum Board in 1872, in which it was stated that "the necessity of revaccination, when the protective power of the primary vaccination has to a great extent passed away, cannot be too strongly urged. No greater argument to prove the efficacy of this precaution can be adduced than the fact that of upwards of 14,800 cases received into the hospitals, only four well-authenticated cases were treated in which revaccination had been properly performed, and these were light attacks. Further, conclusive evidence is afforded by the fact that all the nurses and servants of the hospitals, at one time to the number of upwards of 300, who were hourly brought into contact with the disease, who constantly breathed its atmosphere, and than whom none could be more exposed to its contagion, have, with but few exceptions, enjoyed complete immunity from its attacks. These exceptions were cases of nurses or servants whose revaccination, in the pressure of the epidemic, was overlooked, and who speedily took the disease; and one case was that of a nurse who, having had smallpox previously, was not revaccinated, and took the disease a second time." Revaccination is to the general public what the safety-lamp is to the miner; it affords a protection which only exceptional circumstances render inefficacious.—*Med. Times and Gaz.*, Feb. 10, 1877.

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A Smoker's Disease.—M. MAURIAC, Surgeon of the Hôpital du Midi, has just added another to the special diseases of smokers. He has described, under the title of *plaque des fumeurs*, a morbid change of the mucous membrane of the tongue and mouth, a special psoriasis. This lesion may degenerate into epithelioma; and, according to M. Mauriac, cancer of the lips and tongue has often no other origin than this. Both are common among men, and very rare, as might be supposed, among women.—*London Med. Record*, Feb. 15, 1877.

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On the Use of the Ophthalmoscope in Nervous Diseases.—For fourteen years it appears that M. BOUCHUT has reviewed in the month of December his ophthalmoscopic work at the Children's Hospital, Paris. In a clinical lecture reported in the *Gazette des Hôpitaux*, January 4, he gives the first part of his review for 1876. The record of cases is exceedingly valuable, but we venture to doubt whether these or any other cases will justify the extraordinary pretensions which M. Bouchut makes for ophthalmoscopy in a diagnostic point of view. We do not wish to dispute M. Bouchut's claim to having at least largely helped to diffuse the knowledge and employment of this mode of research, but what can be thought of the following paragraph? "To-day the cranial cavity is no longer closed to observation as it was in the olden time, before the first works which I published in

1862." "*That which occurs in the meninges, in the brain, and in the spinal cord, can be recognized in the fundus of the eye by alterations visible with the ophthalmoscope.*" "We can, from a physical phenomenon observed in the eye, draw conclusions as to a cerebro-spinal alteration, just as from a cardiac or pulmonary murmur we can deduce this or that lesion of the heart or the lungs."

To begin with, the cranial cavity was not absolutely closed to observation before the year 1862. M. Bouchut has devoted himself to children's diseases. Let us take one of the most insidious of the nervous diseases of children—viz., tubercular meningitis. A Scotch physician (Dr. Robert Whytt) had come to a very shrewd diagnosis, and written a clinical account of this disease, which has never been surpassed, more than ninety years before M. Bouchut began his ophthalmic expositions. But has M. Bouchut so completely opened up the cranial cavity to observation? Let us consider the significance of one, and that the most important, of the opthalmoscopic appearances observed in diseases of the cerebrospinal system—viz., optic neuritis. Surely Dr. Hughlings-Jackson's dictum ("double optic neuritis generally means 'coarse' disease within the skull") embraces all that we are justified in concluding when we find this condition in any given case. Nobody has insisted more strongly than Dr. Jackson that optic neuritis does not help us more than this. We neither learn from it the nature of the change, nor the locality of the change; and the mechanism of the connection between optic neuritis and coarse cerebral disease is still inexplicable. There are, indeed, most important limitations to the dictum itself. Firstly, the neuritis may be idiopathic, or, at all events, unassociated with any cerebral disease to be discovered post-mortem. In a case of Mr. Brudenell Carter's there were typical choked disks, but post-mortem examination disclosed the existence of kidney disease, and no brain disease at all. Secondly, when optic neuritis and cerebral disease are associated, the latter is not always coarse—tubercular meningitis, for instance. Thirdly, there may be "coarse" cerebral disease without optic neuritis (*vide* Dr. Hughlings-Jackson, *Ophthalmic Hospital Reports*, May, 1876). Similar remarks might be made on other ophthalmoscopic phenomena. For example, we recently saw post-mortem a well-marked case of tubercle of the choroid in a patient who, though manifesting abundant miliary tubercle in the abdomen and throrax, had none in the brain or its membranes. But if we are greatly in the dark about their interpretation in cerebral diseases, how little do ophthalmoscopic changes teach us respecting the nature of spinal-cord disease! Suppose M. Bouchut finds atrophy of the optic nerve in a case of locomotor ataxy, how much does that positively teach him as to the extent and position of the lesion? To dogmatize on the results of a method of research which is still in its infancy appears to us only calculated to discredit it altogether. But to whatever perfection ophthalmoscopy may be brought, neither the ophthalmoscope nor any other instrument will free us from the necessity of considering any given case in its clinical entirety—the symptoms and the history as well as the signs.—*Medical Times and Gaz.*, Feb. 17, 1877.

One-sided Deafness in relation to Military Service.—At a recent meeting of the Medical Society of the Vienna Garrison (*Feldarzt*, December 12), Prof. POLITZER was invited to give his opinion as to whether one-sided deafness should act as a disqualification for active military service, which it does in the German army. In reply, he observed first, that persons who were partially or totally deaf on one side, very frequently heard just as well, especially at long distances, as those whose ears were in quite a normal state. But this one-sided deafness is connected with an anomaly in hearing which is of the highest importance—that is, it is accompanied by an impossibility of judging of the direction of sound. Even in the normal condition of the organ of hearing, the power of judging of this is possessed only in an imperfect degree; for the distinguishing the direction of the sound is no act of the sensation itself, but is the result of our judgment, based on preceding experience. The source of sound will be referred to the right or left accordingly as the sound strikes the one or other ear more forcibly; but our judgment as to its direction becomes entirely uncertain if both ears are in the same position as regards the source of sound—when we are frequently unable to decide whether the sound comes from before or behind. Prof. Politzer having observed that so many persons suffering from diseases of the ear not only were not able to indicate the direction of the source of sound, but frequently referred it to quite the opposite of the reality, instituted some experiments. He found that if a loud-ticking watch be held over the vertex of a person with closed eyes, and moved over the head from before backwards, he will not be able to state with certainty whether the watch is in front, above, or behind. Whenever he closes one ear, the sound of the ticking is immediately transferred to the side of the open ear. Although our judgment concerning the direction of the source of sound is greatly assisted by the sense of sight, yet, even with this aid, the decision on the point will be surprisingly altered if one ear be closed. When this is done, the ticking of the watch placed over the vertex, even if its position be seen, will be projected in the direction of the unclosed ear. From these and other experiments, Prof. Politzer concludes that our judgment concerning the direction of sound can only be determined by binauricular hearing, and even with this we are not always able to be certain. Similar results followed trials with speaking. Most surprising were the errors made in well-marked one-sided deafness. Even with the greatest attention the subjects of this were often unable to detect the direction of the sound until they saw the object producing it, or had acquired the knowledge by frequent change of position of the head. This was very remarkable in the hunting-field, when the sounds were often supposed to come from the opposite direction, if the deaf ear was turned towards the spot whence the sound came.

From the foregoing it results that the exemption of persons with one-sided deafness from active military service is amply justified. It is evident that the placing such persons as outposts on a dark night might give rise to dangerous consequences.—*Med. Times and Gaz.*, Feb. 10, 1877.

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Action of Metals in Anæsthesia.—At the meeting of the Biological Society, January 13, Prof. Charcot gave an account of some experiments now carrying on at the Salpêtrière, with the aid of M. Burq. It is well known, he observed, that in hysterical patients one side of the body is often struck with anæsthesia, which is not transitory, but permanent. Now, if in a certain number of such cases a twenty-franc gold coin or two be placed on some part of the anæsthetized side, it will induce in fifteen or twenty minutes a return of sensibility throughout a zone extending from five to ten centimetres above and below the points on which such coins have been placed; and this sensibility will persist throughout a whole day. In other hysterical subjects gold produces no such effect, and copper requires to be employed, while in others it is zinc; but it is gold which most frequently so operates. One day, M. Charcot, wishing to show those who accompanied him how evident the hemi-anæsthesia was in a hysterical patient, traversed the length of her arm with a long needle. The patient uttered a terrible cry, and it was then ascertained that M. Burq had applied the metal to her arm the same morning. Not only does the sensibility return, but there is an elevation of temperature, and the dynamometer indicates an increase of force. The return of sensibility does not take place suddenly, the patient feeling first by cross-purposes, *e. g.*, ice will feel like a hot body. It is well known that hysterical anæsthesia disappears under the influence of faradization, and it may be asked whether these metallic applications give rise to a simple electrical phenomenon. This is a question which will be decided by an investigation by physical and physiological experts which is now being made. However this may be, the fact itself has been proved in the plainest manner. Without adopting M. Burq's views on what he calls metallo-therapeutics, Prof. Charcot acknowledges that his point of departure is perfectly exact. He added, that the metals act not only on the anæsthesia of the hysterical, but furnish absolutely the same results when this is due to organic causes, *i.e.*, dependent on cerebral lesion.—*Med. Times and Gaz.*, Jan. 27, 1877.

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Cases of Retarded Putrefaction and Prolonged Rigor Mortis.—M. TARCHINI BONFANTI records two remarkable cases of retarded putrefaction and prolonged rigor mortis that fell under his observation in Milan. Two women were found with their heads battered in, and who had died with profuse hemorrhage. Rigor mortis was fully developed, and little or no putrefaction, and he and several other surgeons and physicians at first believed that not more than thirty-six hours could have elapsed since death had taken place. On consideration, however, it occurred to him that the temperature had been persistently low (50° to 54° Fahr.), the atmosphere dry, the air in the rooms had been but little changed in consequence of the windows and doors being closed, and the amount of light admitted was small. The bodies were lying on a Dutch-tiled floor, were extremely exsanguine, contained very little food in the digestive tract, and the death had evidently been sudden. The mistress was old and tolerably well-nourished, the servant thin and young. From these circumstances, all of which were favourable to the prolongation of the state of rigor mortis and the prevention of putrefaction, M. Tarchini Bonfanti arrived at the conclusion that a longer period than thirty-six hours had probably elapsed, and they might have remained in the condition in which they were found for seventy-two hours, or three days, or even longer. On the trial of the assassin it proved that death in the above cases had taken place four days and a half prior to the discovery of the bodies. The cases are important from a medico-legal point of view, as showing the caution that should be exercised in pronouncing upon the date of death from the presence of rigor mortis and the absence of putrefaction.—*Lancet*, Feb. 10, 1874.

Influence of Coloured Lights on Maniacs.—Dr. TAGUET, Physician to the Asylum of Ville-Evrard, has experimentally investigated the sensational statements of Dr. Ponza as to the influence of coloured light in subduing the violence of mania. In a room whose windows were of blue glass, and whose walls were painted the same colour, a patient labouring under strong maniacal excitement was placed for three hours. The light seemed to fatigue him as he kept his eyelids closed during most of the time, but no calming tendency was apparent. For several days the experiment was continued, but with negative results. The second case was one of acute mania with refusal to take food, etc.; there was no improvement. A number of others were tried, including some hysterical patients, but in all cases the light seemed to weary rather than soothe them. The Director-General of the Asylum at Moscow has given a full trial to the new treatment, but without the slightest result.—*Dublin Journal of Med. Sci.*, Jan. 1877, from *Annales Médico-Psychologiques.*

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Deaths from Chloroform.—Mr. J. H. WILSON, of Peterborough, records (*Lancet*, Feb. 10, 1877) a case of this after the inhalation of two drachms of the anæsthetic, by a man aged 52 years, suffering from strangulated inguinal hernia.

The *British Medical Journal* for January 20 reports a case which occurred the preceding week at University College Hospital. The anæsthetic was taken for removal of a piece of carious bone from the stump of an arm. The patient had taken ether safely at a previous operation.

The same journal for the succeeding week contains the reports of two more cases. One occurred at the Wolverhampton and Staffordshire General Hospital, the chloroform having been inhaled prior to the amputation of a fractured fore-finger; the other case was that of a lady who was to undergo an operation for removal of a tumour from the throat.

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A New Poison.—At the meeting of the Academy of Sciences of the 7th inst., a new poison was presented by M. Vulpian for MM. Ernest Hardy and Gallois. It is named inea, and is a heart-poison already studied in France by MM. Pollaillon and Carville, and in England by Dr. Fraser. Like digitaline, but in a stronger degree, it kills frogs and other animals, the heart being in systole. The discoverers scarcely know as yet how to class it, but they are convinced that it is not an alkaloid.—*British Med. Journ.*, Feb. 24, 1877.

A Catalogue of Works on Naval and Military Medicine.—Dr. **Friedrich Fraenkel**, of Glogau, a German army surgeon, is issuing a systematic catalogue of every work which deals with the relations of medicine to the requirements of soldiers and seamen, in the hope that it may be of service to those who are engaged in literary work connected with these subjects. It appears under the title of "Bibliotheca Medicinæ Militaris et Navalis: contributions to the literature of military and naval medicine," and is published by Gutmann, of Berlin. It is appearing in parts, in which the works are arranged (*a*) alphabetically according to the authors' names, and (*b*) according to the subjects. Dr. Fraenkel desires the co-operation of all writers on military hygiene, etc., librarians, societies, and others, in completing the catalogue; and any works which may be forwarded to him will be returned within a short period.—*Med. Times and Gaz.*, Jan. 6, 1877.

German Surgical Chairs.—Prof. **Czerny**, of Freiburg, has been called to Heidelberg to occupy the Professorship of Surgery vacant by the death of Professor Gustav Simon; and Professor Maas, of Breslau, succeeds him at Freiburg.—*Med. Times and Gaz.*, Jan. 27, 1877.

Personal.—Sir James Paget, Bart., has been gazetted Sergeant-Surgeon in Ordinary to the Queen, vice Sir William Fergusson deceased. Mr. Prescott Hewett, President of the Royal College of Surgeons, has been appointed Sergeant-Surgeon Extraordinary, succeeding Sir James Paget in that honourable office; and Mr. John Eric Erichsen, Surgeon to University College Hospital, in recognition of his long and distinguished career as a practical and scientific surgeon, has been appointed one of her Majesty's Surgeons Extraordinary. It is rumored that Mr. Prescott Hewett will shortly be made a baronet.

Obituary Record.—At Berlin on the 24th of January, aged 80 years, Dr. Johann Christian Poggendorff, Prof. of Physics at the University of Berlin. Dr. Poggendorff is best known to the profession as the editor of the *Annalen der Physik und Chemie*, which position he filled for fifty-two years and until his death.

—— at London, on the 11th of February, aged 69, Sir **William Fergusson**, Bart., Sergeant-Surgeon to H. M. the Queen, and Senior Surgeon to King's College Hospital.

Sir William was a Scotchman by birth, and studied medicine at Edinburgh. In 1840 he removed to London to accept the Chair of Surgery in King's College. He was specially distinguished for his advocacy of conservative surgery. He was a skilful, brilliant, and imperturbable operator, and his professional judgment was held in the highest esteem. As an instance of his coolness the following anecdote is told: Once, when operating for the removal of a deep-seated tumour of the neck, a fearful gush of blood announced the severance of a large artery. An assistant promptly thrust his finger into the wound to arrest the flow, when Fergusson coolly said, "Jist get your finger out of the way, mon, and lets see what it is," and quietly securing the vessel, completed the operation.

His contributions to literature were few, the chiefest of them being his *Practical Surgery*, published in 1842, and his *Progress of Anatomy and Surgery in the 19th Century*, published in 1867. He will always be remembered for those changes and improvements in surgery which he introduced, and which include his operations for hare-lip and cleft-palate, excision of joints (especially of the hip and knee), and removal of the upper jaw with the labio-nasal incision. Sir William was created a baronet in 1866, and in 1867 he was appointed Sergeant-Surgeon to the Queen. In 1870 he was elected President of the Royal College of Surgeons.

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This portly volume is a marvel of condensation. In a style at once clear, interesting, and concise, Dr. Bristowe passes in review every conceivable subject connected with the practice of medicine. Those practitioners who purchase few books will find this a most opportune publication, because so many topics not usually embraced in a work on practice are adequately handled. The book is a thoroughly good one, and its usefulness to American readers has been increased by the judicious notes of the Editor.—*Cincinnati Clinic*, Jan. 6, 1877.

But any one who wants a good, clear, condensed work upon Practice, quite up with the most recent views in pathology, will find this a most valuable work. The additions made by Dr Hutchinson are appropriate and useful, and so well done that we wish there were more of them.—*Am. Practitioner*, Feb. 1877.

It is impossible to look over its pages without being impressed with the amount of information which they have been made to contain, with no appearance of conciseness at the expense of completeness. A superficial survey even shows that, as a text-book, it is far in advance of those published only a few years ago; and a more careful examination of some of its sections—such, for example, as the one devoted to diseases of the nervous system—demonstrates that in provinces which have accomplished the greatest advances of late years, the author has kept his work quite abreast with the labors of the most reliable clinical observers. Features quite unusual in a purely medical treatise are included in the shape of excellent chapters on diseases of the skin, the affections of the genito-urinary organs in females, which can but result in lessening the tendency on the part of the general practitioner to neglect the important classes of complaints with the feeling that, like derangements of the chief organs of the special senses, they can better be managed by specialists.—*New Remedies*, Nov. 1876.

We recommend highly this book, and feel justified in doing so by the thought that, of its class it is the best we have yet seen. The judicious remarks of the American editor add very much to the value of the work. His jealous guard over American medicine is most praiseworthy: in fact, our only complaint is that so little of his own well-known style appears.—*Obstet. Journ. of Great Britain and Ireland, Am. Suppl*, Nov. 1876.

While he has done what he really intended to do, viz., presented every subject with all possible conciseness and brevity, there is nothing to warrant the conclusion that such a result is due to any want of that thorough preparation and knowledge requisite in a work of greater amplitude and pretension. Indeed, the experienced and candid reader will testify that there are no real evidences of the fact that this work is adapted only to the wants of junior practitioners and students; on the contrary, while the style is concise, it is polished, and conveys, as a rule, what would be demanded by the most experienced practitioners; while the number and variety of subjects discussed is really astonishing. It is a most excellent volume, and will be fully prized by all who possess a copy of it. The American editor has really improved the volume by his additions to it, and deserves warm commendation for his faithful and efficient labors. We have no general works on the practice of medicine that, in many respects, are so fully up to the results of modern researches.—*Journ. of Mental and Nervous Diseases*, Jan. 1877.

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VOL. XXXV. MAY, 1877. No. 413.

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CLINICS.

CLINICAL LECTURES.

Sir William Jenner's Clinque at University College Hospital.—In the course of recent visits to the *clinique* of Sir WILLIAM JENNER, we have collected some notes of his teaching, in respect to current cases of disease under treatment.

Heart Disease in Children.—In an attack of rheumatism, the disposition to inflammation of the heart and its membranes is in direct proportion to the youth of the patient; the younger the heart, the more readily it is affected; and this is a form of malady likely to increase with years. Parents often hope "the child will grow out of it": the heart, of course, must grow; but, if the valves be imperfect, they must become more patent as the size increases; whereas, in other patients, the heart having ceased to grow, the mischief at least remains stationary. The fact is, then, that, as regards valvular diseases, children rather *grow into* their trouble than out of it. The pathology of heart disease is also largely a question of age; for instance, if I were to be affected, it would probably be of degenerative character; but if a child, or even one of you, it would almost always be rheumatic. You must, however, bear in mind its possible connection with albuminuria, with syphilis, or with congenital defect. Independently of these, it will almost surely be the result of rheumatism, though the attack may have been

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so slight as to have been forgotten. If you find evidence of cardiac disease, and if you do not get a history of ordinary causes, you must have very unequivocal evidence to prove they did not exist. The more improbable any point is, naturally the stronger must be the evidence of it. If Dr. Slade tell me he gets spirit-writing, his proofs ought to be above suspicion. If endocarditis in a child be the *only* symptom present, still it must be taken as strong evidence of rheumatism. I remember a boy who came with no definite complaint; but we found a loud friction sound over the heart; a week afterwards, he got swelling of the joints and other evidence of rheumatism. Another case was more striking, and occurred in the young child of a medical friend. It was found late at night suddenly suffering from great dyspnœa; I was sent for hurriedly in the absence of the father, and found a loud mitral *bruit*, which had never been suspected before. Half an hour afterwards the father returned, to find dead the child that he had left apparently well. It was two years old, and, after much consideration, they remembered that, about twelve months before, its limbs had seemed very tender, and it was uneasy in walking; but these symptoms had passed away and been forgotten; no doubt, they indicated the commencement of the attack. The least sign, then, of such trouble in children should be most carefully watched; and remember the great tendency of the malady to recur, so that, after one attack, care should be constant. *Chorea* has been considered a rheumatic inflammation of the spinal meninges. The rheumatism may be a coincidence, but it is certainly a common one. If there be active endocarditis at the time, I consider it certainly rheumatic; but, in estimating the importance of a *bruit*, inquire whether it varies, is absent from certain beats, or whether it be constant; for if the former, it will often be dynamic from irregular action of the papillary muscles. I remember a child with chorea and a *bruit* of organic character, but no other evident rheumatism. In a week, however, he got urticaria, and later a marked attack of acute rheumatism. Another baby with chorea was intensely fretful, and I found the explanation in signs of acute pericarditis, which, indeed, proved fatal soon afterwards.

Ascites is never directly produced by heart disease, but only after organic disease of liver has occurred.

Rachitis.—Sir William Jenner observed that a very large mortality is due to this malady, though it has no place in the registrar's returns. If a child be brought to you with (1) sweating of the head and upper part of the body; (2) tenderness of limbs; (3) strong desire to lie cool, that is, to throw off its bedclothes; (4) or fetid stools; let the child be stripped, and observe its position and the state of its bones. Rickets is popularly associated only with crooked legs; but it really occurs before the deformity, and the latter is the result of mechanical pressure on softened bones. Observe this child bending forward as it sits, and resting on its hands; note the *clavicles* bent at almost an acute angle in their middle. This is from transmitted pressure. Its legs are not bent, for it is never on them; the thighs are sometimes bent from the position of sitting, and sometimes the humerus just below the insertion of the deltoid, from the weight of the arm when raised by that muscle. The back is curved, and this is mistaken sometimes for angular curvature; but observe, you can straighten it out with your hand. Next, see the ribs, and note a groove just external to their cartilages, which feel like "beads." At each inspiration, the atmosphere presses most on the weakest part, *i. e.*, the growing part, near the cartilage, and the groove deepens. The action may be imitated with a piece of lung in a glass jar with artificial diaphragm; depress this, and air enters the lung; now insert in the side of the jar a piece of India-rubber, and see how that also is pressed in by the air at the same time. The child is almost in the condition of a frog as to breathing, the inspiratory power is so feeble. The ribs are so soft, and assist so little, that the whole occupation seems to be to breathe. Such children are very liable to catarrh and bronchitis, and a plug of mucus in a bronchial tube may cause death. Observe the shape of the chest, of small diameter laterally, but deep from before backwards.

The *bones* are enlarged at their ends, as at the wrist and ankles, or at any part where ossification is going on; thus the parietal bones are thickened along their suture. When the bones do harden, they become harder even than normal, and their development is generally arrested—the scapula especially is small and thick—and, if the affection be severe, the child becomes a dwarf. The head, like the thorax, is narrow across, long from before backwards—nearly an opposite shape to that of hydrocephalus. A prominent forehead, or what may be called a "lofty brow," generally means rachitis. We had a classical instance here at one time in the porter at the dissecting-room, whose cranium came afterwards into our museum; and a lady phrenologist, examining our selection, singled it out with "*This is the grandest.*" The fontanelle is often unclosed and depressed; in hydrocephalus, it is raised. Dentition is retarded; this child, nineteen months old, has only two teeth. Recognizing rickets, you will not feel bound to lance gums in expectation. With regard to the general tenderness of surface, it leads to the child keeping as quiet as possible. Whilst a healthy baby will occupy itself in putting its toes in its mouth, etc.: the rickety child also will, as a rule, be "good," contrasting strongly with the tuberculous, who will be irritable.

The fetid stools are like putrid meat. The belly is large; but, remember, all children have large bellies. This is well known to painters who paint from nature. You will observe either they paint it so, or they arrange the position so as to hide it from view. The reasons that make it large are particularly active in the rickety; the parietes are thin, the muscles weak, digestion impaired, the chest-wall ineffective, the diaphragm has to do more, it descends lower, and the liver and viscera are pushed forward.

As to the *cause of rickets*, it is clearly traceable to mal-hygiene. Very rarely is the first child rickety; but, when one is so, mostly the subsequent ones also. I speak of the lower ranks. Say a coachman marries a servant. They have at first room enough and comfort enough, and the first child is healthy; others come; the mother nurses long; the condition of her blood is impaired, the air is less pure. If work be not good, the food is less; and the result is seen in the children. Amongst the wealthier classes, you may get an occasional rickety child in a family, traceable often to oversuckling or temporary troubles.

Treatment.—In the infant, if the mother be ill, provide a nurse; in all attend carefully to the feeding. You must see it yourself. It is your instrument of cure. What should we say of a surgeon who did not look at his instrument before using it? Milk is good, but do not press too much of it. You must see the stools, and if undigested curd be passed, you must lessen the milk or thin it; a little pepsine will help. Softened bread or barley may be given, not corn flour as a rule. Minced-meat is often advised, but is not good; if any meat be given, let it be well pounded, and pressed through a sieve. Beef-tea, well made, is better. Of remedies, cod-oil is so successful that we have been cautioned how we give it, lest "it should set the bones too quickly and induce deformity;" but this is nonsense. It gives admirable results.

Hydatid Cyst; Diagnosis.—A man presented a rounded projection at the ensiform cartilage and lower ribs of right side; no pain, no jaundice, feels well; *the swelling is in the liver, for you can feel its lower margin rising and falling with respiration*, and the swelling is above the lower margin. Note that the diaphragm is not so damaged as to be inactive, whilst in malignant and inflammatory disease it commonly is so. The liver is probably unchanged in texture; the growth has been gradual, and revealed only by the present swelling; the upper surface is free; there is obscure fluctuation, but no "hydatid fremitus;" the absence of this is not stronly negative, though its presence would be positive.

Addison's Disease. — The points that were specially described by Addison were —1. The brown coloration; 2. The anæmia; and 3. The weakness. Observe that exposed parts are most coloured, as the knuckles; also blistered surfaces, parts that are naturally pigmented, and parts that are pressed upon: the nipples and umbilicus, the margins of eyes, roots of eyelashes, the buttocks, and hips. Often the suprarenal capsules are diseased, but I have seen a case where they were not diseased, but branches of the sympathetic ganglia passed through the lymphatic glands. It is possibly the sympathetic which is at fault.

Enteric Fever; Beef-tea v. *Milk; Hemorrhage.*—"In a case, now at the fourteenth day, there is looseness of the bowels. On examining the stool, I find a separate undigested curd of milk. This curd has acted as an irritant and induced the diarrhœa, therefore you must thin the milk, and replace it more or less by beef-tea. It has been too much the fashion to give much milk without due regard to its digestion. As remedies you may give some starch with bismuth in enema." At the next visit, some hemorrhage (of which the patient was kept in ignorance) was reported by the nurse. On inspection it was found to be about half a pint of dark fluid blood. "Now, the most important point is, that this patient do not sit up for any purpose. A case which occurred during my student days impressed me very much. He had had hemorrhage like this, but did not seem very bad; his pulse was 84; his mind clear; he was allowed to rise to the night-stool; the hemorrhage recurred, and ended fatally in a few minutes. A mesenteric artery had been opened. You must then, by position, take off the weight of the blood-column. Omit milk altogether, the curd might irritate; give beef-tea and arrowroot; a little softened bread; a little brandy, two drachms every three or four hours, to improve the nerve-tone; give him three grains of acetate of lead with acetic acid every four hours, and an opiate enema night and morning. Observe there is no great distension of abdomen, and there is no tremor. I conclude the ulceration is not deep. *When tremor is disproportionate to other nerve-symptoms, it indicates more depth of ulceration.*" The patient did well.—*Brit. Med. Journ.*, Oct. 28, 1876.

Unusual Form of Progressive Locomotor Ataxy, with Anæsthesia of the Portio Mollis. By JULIUS ALTHAUS, M.D., Phys. to Hospital for Epilepsy and Paralysis.

The following case is interesting, from the peculiarly sudden manner in which the symptoms of ataxy became developed; from the circumstance that a pair of cerebral nerves, which but rarely suffer in this disease, viz., the portio mollis of the seventh pair, were in a state of complete anæsthesia; and finally from the favourable results of treatment, under apparently unpromising conditions:—

H. W., æt. 32, married, and father of three children, a butcher by trade, was admitted into the Hospital for Epilepsy and Paralysis, Regent's Park, under the care of Dr. ALTHAUS on January 10th, 1876. The examination of the patient was unusually troublesome, as owing to his being completely deaf, all questions had to be written down on a slate. It appeared that the ataxy dated from May, 1875, but that for some time previous to that the patient had been out of health, and suffered from persistent sickness, and total loss of appetite. In May, 1875, he suddenly began to squint and see things double, but whether this was owing to an affection of the third, fourth, or sixth nerve it is now impossible to determine. The strabismus and diplopia only lasted for a few days; but about the same time the patient began to suffer from distressing vertigo, and a roaring noise in the head. It appeared sometimes like thunder, or as if there were explosions of gun-powder in his head, or bells ringing, and all kinds of other strange noises. This lasted for about a month, during which time the hearing of the patient became gradually diminished; and at last he became completely deaf. He now noticed that he did not walk so well as before, more particularly in the dark; and the peculiar sensation as of walking on cotton or bladders presented itself. Pains of a character peculiar to ataxy began to shoot through the lower extremities, more especially in the night, and on exposure to wet or cold. The ataxy rapidly increased, in spite of medical treatment, so that he became helpless in a short time; and when he entered the hospital he had already reached the third stage of the disease, in which not only the co-ordination of movements, but also muscular power, suffers.

There was no hereditary tendency to nervous affections, such as paralysis, insanity, or neuralgia. The patient had always been a steady, hard-working man, not given either to alcoholic or venereal excesses. He had never had syphilis nor gonorrhœa. He does not smoke. He had, however, in his trade as a butcher, been obliged to go about a great deal in all kinds of weather, and in the small hours of the morning, and had lately had a good deal of anxiety about money matters. No symptoms indicating cerebral mischief were present; speech, intellect, and memory being quite normal. All the cerebral nerves were in functional activity, with the exception only of the auditory nerves. The external and middle ear being quite healthy, the deafness had to be ascribed to neuritis, and subsequent atrophy of the auditory nerves in the semicircular canals. This view was also borne out by the symptoms which had ushered in the disease. There was now constant tinnitus aurium. The physiognomical expression of the patient was peculiar; his features appeared in perfect repose aud unimpressionable, except when a question in writing was put to him. In anæsthesia of the fifth pair of cerebral nerves the expression becomes truly statuesque; but in the present case there was perfect cutaneous sensibility all over the face, and the want of physiognomical play was evidently owing to the utter absence of hearing, and comparative indifference of the patient to what went on around him. The pupils were normal, there was no strabismus or ptosis, no deviation of the tongue or uvula, and no difficulty in masticating or swallowing.

The spine was not tender to pressure or percussion, nor was there spontaneous pain in it; and the pain in the limbs was less marked than some time ago. There was incomplete cutaneous anæsthesia from the waist downwards to the feet, and also incomplete muscular anæsthesia. Tickling the soles produced no reflex movements; and pinching the gastrocnemius and rectus femoris produced hardly any sensation. The muscles were flabby and somewhat wasted, but responded freely to the continuous and faradic currents. The patient could not walk at all, except when supported by two other people, and even then he had the greatest difficulty in stepping out, the peculiar jactitating gait of the atactic being plainly discernible. The helplessness was so great that it verged on paralysis. He could only stand when supported by two sticks, and when he closed his eyes he reeled like a drunken man. Yet he could when lying down or sitting on a chair move his legs and feet more freely than a patient can do who is suffering from myelitis or a high degree of spinal congestion.

The sexual power had been gradually lost during the last sixth months, and the bladder and rectum suffered in the usual manner. There was great difficulty in passing water, the patient having to strain for fifteen or twenty minutes before he succeeded in voiding a few ounces of urine. Occasionally there was incontinence. The urine was habitually neutral, and contained a large excess of urea and phosphates, but no albumen or sugar. The bowels were confined, and when purgatives were administered they acted so rapidly that the feces were voided before the patient had time to reach the commode.

The upper extremities were unaffected, with the exception of a slight feeling of numbness in the third and little fingers of the left hand. The heart and lungs were healthy. The appetite, however, was very bad, and digestion much impaired; the tongue furred. There was tenderness in the right hypochondrium, and increased dulness in the region of the liver. The patient was considerably emaciated, and had a sallow and dyspeptic complexion. He was ordered argenti nitratis gr. 1–6th, bis die, in pill; sodæ hypophosphitis gr. x. in a little infusion, likewise twice daily; and gr. 1–6th of res. podophyll. at bedtime.

March 20th. The nitrate of silver has been gradually increased to half a grain twice daily, but has produced no favourable influence upon the ataxy. There is, on the contrary, increased helplessness, and more frequently than before inconvenience of the bladder and bowels.

28*th*. The patient was suddenly taken with vertigo and insensibility, which lasted for about three hours; there were no convulsions. The complexion became of a deeper yellow; the tongue had a dirty brownish coat; there was total loss of appetite, and the excretions came away. Right hypochondrium very tender, pulse 120, temperature 99.5°. He was given five grains of Plummer's pill, to be followed by five grains of carbonate of ammonia and fifteen grains of bromide of potassium three times daily in mixture.

29*th*. Patient still drowsy. Morning temperature 100.2°, pulse 110; evening 101.5°, pulse 120. General condition much the same.

30*th*. Morning temperature 99.6°, evening 101.4°. Rather less comatose.

31*st*. There is decided improvement today; the expression brighter, the complexion less dark, and the temperature has fallen to 99.2.°

April 1*st*. There is more appetite; patient has retained feces for the first time. Temperature 99.2°, pulse 90.

10*th*. General condition good; but ataxy and deafness exactly the same. The liquid extract of ergot was now given in half-drachm doses thrice daily.

From this time forward the patient made an excellent recovery. He is now (Feb. 26th, 1877) able to walk briskly without a stick; feels pinching the skin and muscles of the lower extremities well; has perfect control over bladder and rectum; can stand firmly with his eyes closed, and has no difficulty in going with his legs and feet through the various test movements which are usually employed in such cases. The ergot was gradually pushed up to a drachm three times daily, and throughout the course was very well borne. It was only discontinued once during last summer, when the patient complained of general *malaise*, with loss of appetite and a feeble pulse. The citrate of iron and quinine was then substituted for the ergot, with good results as far as those symptoms were concerned; but it was discontinued after a fortnight, as the ataxy did not improve, and the administration of ergot was resumed in forty minim doses. There have never been at any time symptoms of so-called ergotism, which, at least in that form which is generally described in the text-books, Dr. Althaus looks upon as a myth.

The only symptoms of illness which still persist are deafness and tinnitus aurium. Mr. Dalby kindly examined the patient's ears very carefully some weeks ago, and confirmed the diagnosis of anæsthesia of the portio mollis in the semicircular canals, at the same time giving it as his opinion that the case was quite hopeless, as far as any recovery of hearing was concerned. Dr. Althaus has, however, to give the patient a last chance, ordered the use of the continuous galvanic current to both ears in the following manner: The external meatus is filled with warm water, and the negative electrode, in the form of fine metallic probe, dipped into the water, while the anode, armed with a moistened sponge, is applied to the hand of the opposite side. The current is now alternately made and broken, the result being that each time, on making the current, the patient hears a distinct "blowing" sound, which has quite recently become accompanied with a "ringing" sound. To all external sounds the patient, however, continues as yet quite insensible.

Remarks.—Acoustic neuritis is of very rare occurrence as a symptom of ataxy. Amongst 220 published cases it is only mentioned in nine that there was a diminution or loss of hearing, and in these it only came on in the later stages of the disease, but not in the commencement of it, as in the present case. On the other hand, affections of the optic and of the motor nerves of the eye are most common in the early period of ataxy. It is, perhaps, a matter of surprise that the portio mollis should be so rarely implicated, since ataxy is essentially a disorder of equilibration; and it is now well understood that the auditory nerve is not simply a nerve of special sense, but has a distinct relation to certain centres which regulate the equilibrium of the body. The connection is effected by afferent fibres which proceed from the portio mollis to the crura cerebelli, and it accounts readily for the symptom of vertigo which accompanies acoustic neuritis. It resembles optic neuritis, which is not uncommon in the commencement of ataxy, by being a more permanent affection, while the corresponding disorders of the motor and sentient nerves—such as strabismus, diplopia, ptosis, nystagmus, facial anæsthesia, etc.—are generally recovered from.

That there should be tinnitus aurium, after complete deafness has existed for a considerable time, is apparently strange; but we have analogous facts with regard to the motor and sentient nerves. Atrophy of the posterior roots, or of the sentient nerves themselves, leads to the worst forms of neuralgia, while atrophy of the motor nerves causes certain forms of spasm.

Another practically important point in this case was the disorder of the digestive organs, which had preceded the development of the complaint. This is a matter on which no stress has been laid in the systematic descriptions of ataxy, but which Dr. Althaus has seen sufficiently often to merit attention. Loss of appetite and severe vomiting occur sometimes previous to the outbreak of the disease of the cord, and in other cases accompany it throughout its course, and appear generally to accelerate its progress in a marked manner. In these cases there is generally a great excess of lithates in the urine, deserving the name of lithæmia. The liver seems to be the organ which is chiefly affected, and should be carefully examined and treated. By severe or repeated attacks of this form of dyspepsia the system is very much enfeebled, and the patient then falls a prey to ataxy, provided the conditions favourable to its development—viz., over-exertion in wet and cold, accompanied by mental anxiety, be present.

A further feature of interest was the exceedingly rapid progress of the disease. The patient was in a few months reduced to complete helplessness, while in the majority of cases from five to ten years elapse before such a condition is reached. The prognosis in ataxy is generally bad in cases which progress rapidly, and which are accompanied with affections of the cerebral nerves, more particularly of the nerves of the special senses. It was, therefore, all the more satisfactory that in the present case, where both these unfavourable conditions existed, the faculty of co-ordination, and the functional energy of the bladder and rectum, should have been restored by treatment.—*Medical Examiner*, March 22, 1877.

HOSPITAL NOTES AND GLEANINGS.

Persistent Gonorrhœa of the Duct of the Left Gland of Duverney.—G. F——, aged twenty-three, single, was admitted into the Edinburgh Royal Infirmary, under the care of Dr. MATTHEWS DUNCAN. She said that she was exposed to the risk of venereal infection five years before, and that ever since this she has had a vaginal discharge. For a month past she had suffered greatly from frequency and painfulness of micturition. The following notes were taken at the time of admission.

She is a strong, healthy woman; menstruation regular. The urine is found to contain pus, which was afterwards found to be vaginal. There is a neuromatous polypoid caruncle at the orifice of the urethra. The vulva presents some spots of superficial inflammation. The hymen has been lacerated; its free edge is at several points acutely inflamed. About the lower part of the vagina there is some purulent discharge, and on the same part, near the hymen, are some red spots denuded of epithelium. There are swelling and redness of the cervix uteri, with a ring of ulceration around the os. The cavity of the cervix is filled with viscid mucopus. The bladder is found, by sounding, to be capacious, soft, and not tender. The urethral caruncle was excised.

The catarrh of the cervix was successfully treated by a single application of a stick of zinc-alum about an inch long, managed in the usual way. In addition, a very weak solution of the sulphates of zinc and alum was used daily as a vaginal lotion.

After three weeks, the irritability of

the bladder having disappeared on the removal of the urethral caruncle, there still remained a purulent discharge, which accumulated about the orifice of the vagina; and in the same region there was a degree of redness of the mucous membrane.

On careful examination, it was found that the left duct of Duverney's gland was full of pus, several drops being easily squeezed out of it. This was treated by injecting on two separate occasions a solution of nitrate of silver, twenty grains to an ounce, by means of a syringe for the lachrymal duct.

Soon afterwards the patient was dismissed cured.

Remarks.—In this case, the irritability of bladder was naturally, before ocular examination of the urethra, supposed to be a part of the results of the old gonorrhœa. The caruncle of the urethra was also a natural explanation of it, and its removal by scissors demonstrated that the irritability owned no other cause.

The inflammation of the vulva and lower part of the vagina was in like manner kept up and rendered intractable by the persistent discharge of pus from the duct of Duverney's gland, the inflammation of which was not subjected to treatment. This gonorrhœa was not earlier discovered because the glands of Duverney were not enlarged or inflamed, as they often are in such cases. There was no tenderness or swelling to call attention to the part. The removal of the inflammation of this duct was necessary to complete the cure of the case.—*Lancet*, March 3, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

American Medical Association. — The annual meeting of the American Medical Association will be held in Chicago on Tuesday, June 5th, at 11 o'clock, under the presidency of Dr. Henry I. Bowditch, of Boston.

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The Association and the Pharmacopœia. —At the last meeting of the Association resolutions were introduced by Dr. Squibb, of New York, relating to the publication of a pharmacopœia by that body, and were made the special order for the second day of the ensuing meeting. Coming from such a distinguished source, and referring to questions of the deepest moment to the profession at large, it is important that the project should receive careful and thoughtful consideration from every member of the Association. Each point involved, whether direct or remote, should be maturely weighed, and there are many points which are not apparent at first sight, but which yet may in time be found to be of no little importance.

To properly appreciate the questions raised, it is important to remember that the existing "Pharmacopœia of the United States" is copyrighted, and is published by authority of the "National Convention for revising the Pharmacopœia," which is composed of delegates from all incorporated State medical societies, incorporated medical colleges, incorporated colleges of physicians and surgeons, and incorporated colleges of pharmacy throughout the United States. It will be observed that the American Medical Association has no representation in this convention.

Dr. Squibb's resolutions for the assumption by the Association of the ownership, control, and management of the United States Pharmacopœia, to be offered at the ensuing meeting, are as follows:—

"*Whereas*, The American Medical Association, as being the only organized body which represents the medical profession of the United States of America, may fairly claim the right to control all the general rights and interests of the profession not controlled by statute law; and,

"*Whereas*, 'The Pharmacopœia of the United States of America' is among the most important of such general rights and interests, and has not heretofore been under the direct control of this Association, but has been managed by a representative body similar to this, and for the most part embraced in this body, though representing only a small part of the medical profession; and, "*Whereas*, This smaller body, known as the 'National Convention for Revising the Pharmacopœia,' has given evidence that its plan of organization, though well adapted to the wants of the profession in the past, is insufficient for the growing necessities of the present and the future materia medica; therefore, be it

"*Resolved*, First, That the American Medical Association does, now and hereby, assume the ownership of 'The Pharmacopœia of the United States of America,' and, as the superior representative body of the organized medical profession, does, now and hereby, relieve 'The National Convention for Revising the Pharmacopœia' from any further acts of ownership, control, or management of the Pharmacopœia.

"*Resolved*, Second, That the medical societies and colleges, which, in 1870, sent delegates to both this Association and the National Convention, do, through their delegates now present, relieve the officers of the National Convention from the duty of issuing a call for a convention in 1880, as provided for by the last convention; and that any society or college which does not desire to relieve the officers of the convention of 1870 from this duty, and does not desire that these conventions should now cease, be now heard through its delegates in this body; and that a failure to oppose this resolution at this time shall be construed to signify acquiescence in its object.

"*Resolved*, Third, That the President of this Association notify the President of the National Convention, or his successor, of this action taken by this Association, and request him not to issue a call for a 'General Convention, to be held in Washington, on the first Wednesday in May, 1880,' as provided for by the General Convention of 1870, and ask him to make his decision in the matter known to the president of this Association. But, if the president of the National Convention, or his successor in office, should fail to reply, such failure shall be construed to mean acquiescence in this action.

"*Resolved*, Fourth, That 'The Pharmacopœia of the United States of America' be hereafter issued only by the authority of this Association; and that it be the only standard for the materia medica recognized by the medical profession of the United States of America."

Dr. Squibb's plan is for the Association to take possession of the Pharmacopœia of the National Convention, and then to reconstruct it according to the views he expressed at the preceding meeting. The first part of this project he proposes to accomplish by the adoption of the above resolutions, of which a recent writer ("*The United States Pharmacopœia and the American Medical Association*") truly says, "any assemblage has the right to pass a resolution like the first of these, assuming possession of anything; but such resolutions on paper lead to derision, and when put into practice to civil or criminal litigation." The impotency of the other resolutions is equally apparent.

Dr. Squibb bases the justifiableness of his project on the ground that the constituency of the Pharmacopœial Convention is, "for the most part, embraced" in that of the Association. Is this so? The Association, as is well known, is composed of delegates from State and county medical societies, whether incorporated or not, whereas the Pharmacopœial Convention is composed of delegates from medical colleges, colleges of pharmacy, incorporated colleges of physicians and surgeons, and *incorporated* State medical societies. The roll of the last Pharmacopœial Convention shows that it was composed of 73 delegates from 32 bodies, of which about four-fifths are not entitled to representation in the American Medical Association; or, to be accurate, of which 25 bodies sending 60 delegates are not entitled to representation in the Association, against 7 societies sending 13 delegates so entitled. As the delegates from *incorporated* State medical societies, of which there are but few, form but a small portion of the whole number of delegates comprising the Association, it requires but a moment's thought to see that these resolutions, although they might be unanimously opposed by the delegations from every society represented in the Pharmacopœial Convention, yet might be adopted by an overwhelming majority in the Association.

As if to give his project an appearance

of fairness, Dr. Squibb's second resolution declares that any society or *college* opposing this project "be now heard through its *delegates in this body*," yet, as the colleges and many of the societies are neither entitled nor invited to send delegates, this call upon them is wholly delusive, while at the same time its recognition of their right to be heard is an admission fatal to the whole project. Then, to crown all, we have the clause which is intended to give to the seizure of the Pharmacopœia the semblance of legal acquiescence on the part of its owners; "a failure to oppose this resolution at this time shall be construed to signify acquiescence in its object." We cannot believe that the Association will be guilty of so transparent a subterfuge as this would be, assuming the presence of the absent, and then assuming their consent because they fail to speak.

The voice of the Association, therefore, cannot by any strain of reasoning be held to be that of the Pharmacopœial Convention. But even if the constituency were the same, it would require no laboured argument to show that each has been endowed with authority which can only be altered or abrogated by the original power which gave it.

If Dr. Squibb considers it desirable that the Pharmacopœia should pass into the hands of the Association, the proper plan for him to pursue is to advocate such a course in the National Convention for the revision of the Pharmacopœia, and there ask for the passage of resolutions looking to the dissolution of the convention and the assignment of its property to the American Medical Association; but for the latter to attempt to seize the Pharmacopœia in the proposed violent manner is neither admissible in law nor justifiable in morals.

As regards Dr. Squibb's ideal pharmacopœia he tells us that it includes a dispensatory, and his plan comprehends, in addition to the services of the Committee of Revision, the permanent employment of "one or two editors and other experts" in its preparation, and the publication of a revised edition every five years and of a fasciculus every year. The expenses, and they must necessarily be very heavy, are to be met by the proceeds of the copyright, the value of which, in consideration of the certainty of competition from the maintenance of the existing Pharmacopœia and of the dispensatories published by private enterprise, is sure to be very seriously impaired. If this plan be carried out, Dr. Bartholow's prophecy (*Clinic*, March 24, 1877), that "the members of the Association must be taxed annually to maintain the expensive luxury proposed by Dr. Squibb," will surely be fulfilled.

This suggests another question of considerable moment, which we do not remember to have seen adverted to. Hitherto, the Pharmacopœia indeed has been copyrighted, but this has been done to protect its scientific interests and not the pecuniary advantage of those connected with it, who have freely given their service without pay, and whose very moderate expenditures have been readily met by its sale at a low price. It has been free to every one to make such professional use of as seemed fitting, and the profession has thus through journals, and treatises, and formularies had the benefit of the labours of the Convention and Committee of Revision without fee and without price. Pharmacology and therapeutics have profited by this, and the progress of these sciences has been encouraged and facilitated. To prohibit the freest use of the Pharmacopœia would seem to be unprofessional and illiberal.

All this must of necessity be changed if Dr. Squibb's plan be adopted of a permanent board with experts permanently engaged, the heavy expense of whose labours is to be defrayed by the sale of an enlarged pharmacopœia partaking of the nature of a dispensatory. To accomplish this while endeavouring to avoid the humiliation of soliciting subscriptions or of exacting a tax from members of the Association to meet the outlay, this new Pharmacopœia must be copyrighted in fact as well as in name, and its copyright would probably come to be defended against all intruders whose use of its materials might tend to diminish the profitableness of the speculation. We need hardly call attention to the repressive influence which an authorized monopoly such as this would exercise upon the progress of therapeutic science in this country, or to the degrading position in which it would place the representatives of a liberal profession, whose functions of promoting science and relieving the sufferings of humanity would be diversified by the awkward task of ejecting all intruders from the sacred field entrusted to their guardianship.

No one can doubt that the motives of Dr. Squibb are wholly disinterested, and that he does not in any way contemplate such a result as this from his favourite project. But if the Association enters into business it must infallibly come under the operation of business principles, and these in time could hardly help bringing about the condition which we have described, when the pharmacopœial commission would feel that its duties lay as much in protecting its monopoly as in testing a new drug or a new pharmaceutical process.

In favour of the existing plan of revision it may be said that the basis of organization of the National Convention for the revision of the Pharmacopœia is *thoroughly representative and national* in character. Moreover, this body is composed of experts especially selected on account of their peculiar qualifications for the work by those bodies which are themselves most likely to be abreast of the science of the day (and most of which are *not* represented in the American Medical Association), thus affording the best talent to be found in the country for the task.

The next session of the Pharmacopœial Convention we are told will certainly be called, and from the action of some of the bodies represented in it, and the sentiments which we are informed exist in others, we have no reason to doubt that it will meet and continue the work of revision as heretofore, regardless of any action the Association may take on the resolutions of Dr. Squibb. Should, therefore, such counsels prevail as to lead the Association to form another and rival pharmacopœia, it could only be considered as a great misfortune. The existence of a double standard, each claiming to be authoritative, would certainly lead to unutterable confusion, with the worse probability of mistakes, sometimes fatal, constantly arising from differences in strength of "officinal" preparations made according to the formula prescribed in one or the other work, just as was continually happening in Great Britain during the existence of the London, Edinburgh, and Dublin Pharmacopœias.

A careful examination of the arguments advanced in favour of Dr. Squibb's ideal pharmacopœia leads to the conviction that whatever its advantages may be they can be certainly equally well, and probably much better, secured under the existing machinery for the revision of the Pharmacopœia, and that there is, therefore, no valid reason, even if the proposed way were justifiable, why such important interests as are involved should be jeopardized by the Pharmacopœia being transferred to new machinery and untried hands.

If it is the judgment of the Association that the Pharmacopœial Convention has not a constituency wide enough, and that it does not fully represent the profession of the country, and if both the American Medical and the American Pharmaceutical Association would desire representation in the next meeting of the Convention, there is probably little doubt that on signifying this desire steps would be taken by the executive officers of the Convention to secure the co-operation of those bodies in the revision.

American Gynæcological Society.—The second annual meeting of this society will be held in Boston on May 30. The annual address will be read by the President, Dr. Fordyce Barker, of New York.

Kentucky State Medical Society.—The annual meeting of this Society was held at Louisville, on the 3d of April. Dr. R. W. Gaines, of Hopkinsville, President, in the chair. The following officers were elected for the ensuing year. President-Dr. L. P. Yandell, Jr., of Louisville; Vice Presidents, Drs. J. Dismukes, of Mayfield, and W. B. Rodman, of Frankfort. Frankfort was chosen as the place of meeting in 1878.

Dr. L. S. McMurtry, of Danville, reported that the M'Dowell Monument

Fund amounted to $434. Subscriptions were given on the spot, increasing the fund to $1054.

Dr. Baker, of Shelbyville, offered the following resolutions, which were adopted unanimously:—

Resolved, That this Society is in full accord with the American Medical College convention, seeking to elevate the standard of medical education in this country.

Resolved, That summer schools, which enable students to graduate after from eight to nine months' study, are exerting an evil influence upon the profession.

Resolved, That a winter and summer course by the same school, and graduation at the end of each, tends to deteriorate the standing of the medical profession.

Resignations in the Philadelphia Medical Schools.—Dr. Francis G. Smith has resigned the professorship of the Institutes of Medicine in the University of Pennsylvania, and Dr. B. Howard Rand that of chemistry in the Jefferson Medical College. We understand that the vacancies thus created will not be filled immediately, so that time may be afforded to gentlemen who desire to become candidates, to make known their qualifications.

Charleston Medical Journal and Review.—The editors of the *Charleston Medical Journal* announce its suspension, with an expression of hope, in which we cordially concur, of its renewal in more prosperous times.

A New Dispensatory.—We are pleased to observe the announcement that Dr. Stillé and Professor Maisch have for some years been engaged in the preparation of a new Dispensatory. From the eminent fitness of these gentlemen there can be no doubt that the work will be of value to both the medical and pharmaceutical professions. Our friends of the "Cincinnati Lancet and Observer" are in error in supposing that the "National Dispensatory," on which Professors Stillé and Maisch are engaged, has any connection with the project of Dr. Squibb.

FOREIGN INTELLIGENCE.

Hysterical Aphonia.—In the *Progrès Medical,* 1876, No. 9, MM. Liouville and Deboue describe an interesting case of cure of hysterical aphonia. A girl, eighteen years of age, in consequence of hysterical paralysis of the vocal cords, became at length quite dumb. The authors, by firm and painful pressure in the region of the ovaries, produced a well-marked hysterical paroxysm. During the attack, the patient, for the first time after a long period, began to scream and to speak with a low voice. Repetition of the procedure brought back the voice entirely, but the disordered condition of the nervous system remained.—*British Med. Journal,* Nov. 11, 1876.

Exercise in Diabetes—Dr. Kulz, of Marburg, has observed eight cases of diabetes mellitus in which active exercise was of decided value: but such exercise must consist in vigorous movement in the open air, simple in-door gymnastics are scarcely of the slightest use. In his experience, the best results are obtained by mountain climbing, and provided the patients are fond of such exercise, and can support the necessary exertion, he strongly recommends this treatment in lieu of drugs, provided that careful preliminary experiments have shown that exercise diminishes the excretion of sugar in the particular cases.—*Med. Times and Gaz.,* March 10, 1877.

Copper in Preserved Vegetables.—M. Pasteur, who had been charged with the duty of making a report on the presence of copper in preserved vegetables, especially young peas, communicated the following particulars to the Academy of Sciences of Paris.

Fourteen tin cases of preserved peas were purchased from various grocers in the districts of the Madeleine, etc. Copper was detected in ten out of the fourteen cases, sometimes amounting to $\frac{1}{10000}$th part of the total weight of the contents, not counting the fluid portion. The copper usually became deposited on the surface of the pea, beneath its external cortical layer. Mere inspection of the vegetable, according to M. Pasteur, sufficed to reveal the presence of copper. If the pea had even in a slight degree the green tint of the natural vegetable we might be certain that copper had been employed, for peas preserved without the addition of a copper salt were of a yellowish colour without any tinge of green. In the present state of our knowledge, copper was the only substance by means of which the required tint could be given, and hence its frequent employment. Even admitting that experimental physiology proved that copper and its salts were less poisonous than we had been accustomed to consider them, the guardian of public health should not on that account tolerate their admixture with alimentary substances. If the grocer mixed any extraneous matter with his peas he should be bound at least to mention it on the label.—*Med. Examiner*, March 15, 1877.

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Death from Chloroform.—A case of death whilst under the influence of chloroform recently took place at the Derby Infirmary. Deceased, who was fifty-six years of age, was about to undergo an operation for fistula and hæmorrhoids, but before he was ready for operation, the respiration suddenly became very irregular, he struggled violently, and the pulse, which had up to this time been good, ceased. In spite of all the means resorted to for a considerable time, he showed no signs of rallying from the first. The quantity of chloroform which had been poured into the lint-holder was in all about three drachms. The *post-mortem* examination did not reveal any organic disease.—*Brit. Med. Journ.*, March 17, 1877.

Another case, the patient being a boy aged eight, is recorded in the same journal for Nov. 11, 1876.

Dr. Gustav Judell, privat-docent and chemical assistant in Professor Leube's clinic at Erlangen, was on October 26th, found dead in his bed. He had been accustomed to take chloroform at night as a remedy for sleeplessness, by which he was much troubled; and a bottle containing the anæsthetic was found near him. It appears that vomiting was excited by the chloroform, but that he was too deeply narcotized to eject the contents of the stomach, so that portions of the food remained in the œsophagus and caused death by suffocation.—*Ibid.*, Nov. 18, 1877.

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Death under the Administration of Nitrous Oxide and Ether.—A death has recently taken place in London at University College Hospital during anæsthesia from nitrous oxide gas and ether, being, we believe, the first fatal case which has occurred in this country that can be attributed to this combination of anæsthetics. The patient was a woman fifty-five years of age, who was admitted to the hospital in consequence of strangulated femoral hernia. When admitted she was in a very weak and exhausted condition from constant vomiting, the hernia having been strangulated for over forty-eight hours. She was taken into the operating-theatre, and gas and ether administered by means of Clover's apparatus. In about four minutes she was well under the influence of the anæsthetic, without having exhibited any previous excitement. Taxis was then applied, when almost immediately the patient became pale and recommenced vomiting stercoraceous matter. At the same time the respirations became weak, and the pulse at the wrist imperceptible. The doors and windows of the theatre were at once thrown open, and artificial respiration was carried on for a few minutes. As no obvious benefit resulted, an enema, containing three ounces of brandy, was administered. Fumes of strong ammonia were applied to the nostrils, and ammonia injected into the right median basilic vein, but all without any good result, and the patient died within about ten minutes from the onset of the alarming symptoms. At the autopsy, stercoraceous matter was found in the trachea and right bronchus. The right side of the heart and the large veins were full of dark fluid blood. The ventricular walls were thin and flabby, and the cavities slightly dilated. The left ventricle was empty. The arch of the aorta presented numerous patches of atheroma.—*Med. Times and Gaz.*, March 17, 1877.

High Heels.—The unnatural character impressed on the gait of women by the prevalent fashion of high and narrow heels to the boots is the expression of a perversion of the natural relation of the articulations and muscular action such as cannot but result in serious and permanent damage. The character of the injury which they produce, and the symptoms by which it is expressed, are well described by Dr. Onimus in a recent communication to the Société de Médecine of Paris, which has been published in *L' Union Médicale.* The heel of the boots is not only high, but narrow and inclined forwards, so that the distance between the heel and the point of the foot is lessened, and the foot appears smaller than it really is. This, absurd as it is, appears to be their chief recommendation in the eyes of their wearers. The effect of the oblique position of the foot is, of course, to remove the weight of the body from its natural support—the prominence of the os calcis—and project it forwards on to the plantar arch. Hence one of the most frequent symptoms of which the wearers of these shoes complain is an acute pain in the sole of the foot, in front of and below the external malleolus. There is often considerable tenderness as well as pain, possibly in consequence of inflammation of the calcaneo-cuboid articulation. The forced depression of the anterior part of the foot determines a painful displacement of the articular surfaces. The toes, instead of the heel, first touch the ground, and the walk is clumsy and heavy, instead of light and undulating. The toes become permanently flexed and pressed together, partly in consequence of the narrowness of the front part of the boot, partly in consequence of the overaction of the flexors of the toes, due to the increased pressure on the toes, no doubt partly also to the habitual over-extension of the metatarso-phalangeal articulations, and to the irritation and contraction of the short flexor of the toes in the soles of the foot.

Other muscles are also involved in the disturbance. Those of the calf are commonly in a state of painful contraction. In consequence of the height of the heel, the body has a tendency forwards, and the soleus and gastrocnemius have to overact to correct this tendency. The peroneus longus is also affected in a very marked and uniform manner, and the pains persist longer in it than in the other muscles These muscular pains were the symptom which first drew attention to the effect of the boots. Even the muscles of the thigh may suffer, and the rectus and adductors may be the seat of some contraction. In cases of nervous temperaments the pain and irritation have produced general nervous symptoms of hysterical character. The mode of carriage of the body is influenced by the position of the feet. The centre of gravity must be kept in the line of the base of support, and hence the pelvis is tilted forwards, and anteflexion of the uterus is easily produced, and is, according to Dr. Onimus, actually present in a considerable proportion of the wearers of the "*bottines Louis Quinze*," as they are termed, in consequence of their extensive adoption in the last century. Then, as now, the fashion emanated from Paris, and then, as now, at least one stringent protest was made against the form of shoe, and its consequences on the feet of the wearer were pointed out. This was in 1781, by Petrus Camper, Professor of Medicine at LaHaye. He insisted strongly on the articular deformities almost in the same words as those employed by Dr. Onimus, but did not associate these deformities with the muscular pains.—*Lancet*, Feb. 24, 1877.

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The Hunterian Oration.—The Hunterian Oration was delivered by Sir James Paget on Tuesday afternoon, in the theatre of the Royal College of Surgeons, before a crowded audience, which included His Royal Highness the Prince of Wales, the Duke of Argyll, the Duke of Westminster, the Bishop of London, Dean Stanley, Professor Huxley, Professor Tyndall, and many of the leading members of the medical profession. After acknowledging in a few graceful words the honour which the Prince of Wales conferred on the College by his presence, Sir James Paget proceeded with his oration. He began by showing how, up to nearly the age of twenty years, John Hunter had shown no inclination for study. It was, indeed, from mere idleness and by chance that he drifted into the career in which he was to become the greatest among the great, and the most renowned among the renowned men of science. Coming, however, from a Scotch farm to London was to Hunter like being born into a new world. Gradually there arose in him an insatiable desire for knowledge, and he became possessed of a passion for collecting. He had immense power of toil, his very amusements being what other men would call work. This power enabled him to embrace a wide range of study, in which he was also assisted by his accuracy in observing facts, and the simplicity with which he accumulated them. He was cautious in adopting theories, and slow in publishing them. In short, the character of John Hunter was one of strong will, combined with singular love of truth. Other points on which the orator touched were Hunter's remarkable power of "thinking the truth," his success as the founder of scientific surgery, his great discovery of tying arteries for the cure of aneurisms. In conclusion, Sir James Paget made an effecting reference to the late Sir William Fergusson, of whom he spoke as the great practical surgeon of the day. No one would again watch those eyes which were so keen and yet so kind; those hands which were so strong and yet so sensitive—that clear precision and that rigid calmness. All these had gone, and with them those things which would endear him still more to those who knew him—his warm heart and generous nature; his social grace; but there would still remain his teaching, that the surgeon should have both hands and heart in science, and should strain only to win the best results.—*Medical Examiner*, Feb. 15, 1877.

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Antihydropin.—In Russia, the common cockroach (*Blatta orientalis*) is a favourite popular remedy for dropsy. Dr. P. Bogomolow, of St. Petersburg, has lately (*Petersburg Med. Wochenschrift*, No. 31, 1876) examined its effects in nine cases of Bright's disease, heart disease, and other affections accompanied with severe dropsy, and in all the result was the same. There was an increase in the secretion of the urine and perspiration, with rapid disappearance of œdema, and also almost complete disappearance from the urine of albumen and renal derivatives. The dose was five to ten grains of the powdered cockroaches in the twenty-four hours, but they were also administered as a tincture and as an infusion. These insects do not, like cantharides, produce any irritant action on the kidneys. Dr. Bogomolow has succeeded in extracting from them a crystalline body which he calls antihydropin, and which is their active principle.—*Med. Times and Gaz.*, April 7, 1877.

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Hypodermic Injections in Hernia.—Reporting upon three cases communicated to the Société de Chirurgie, in which strangulated inguinal hernia was easily reduced after the hypodermic injection of morphia, M. Le Dentu observes that in these cases the strangulation was recent, and although the injections certainly assisted their reduction, it is doubtful how far they would have succeeded had the strangulation been more decided and of longer duration. If the surgeon is called to the case immediately, the injection may be of use by dissipating the pain and spasm; but if some hours have elapsed, it will be always of less value than chloroform, which enables us to at once recognize whether the hernia is reducible or the operation necessary.—*Med. Times and Gaz.*, April 7, 1877, from *Gaz des Hôp.*, March 31.

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Obituary Record.—Died, suddenly, at Paris, on March 10th, aged 46, Henri Ferdinand Dolbeau, Professor of Surgical Pathology in the Paris Faculty. Although cut off in the prime of life, M. Dolbeau had already achieved distinguished reputation as a practical surgeon, and had made numerous contributions to medical literature, the most important of which is his Treatise on Perineal Lithotrity.

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None can read it without being impressed with the immense amount of common sense which is possessed by the author, as well as natural tact in interpreting the indications of treatment. His style is clear and agreeable, and he has the faculty of expounding the fundamental principles of medicine in such a way as to give them a practical application to treatment. It is, in fact, one of the most interesting, entertaining, and instructive works of its kind that we have ever read.—*Med. Record*, March 17, '77.

We heartily commend his book to the medical student as an honest and intelligent guide through the mazes of therapeutics, and assure the practitioner who has grown gray in the harness that he will derive pleasure and instruction from its perusal.—*Bost. Med. and Surg. Journ.*, March 8, 1877.

This is a very valuable book, and is well adapted for a young practitioner.—*London Lancet*, March 24, 1877.

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VOL. XXXV. JUNE, 1877. No. 414.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Strangulated Hernia. Delivered at the London Hospital. By C. F. MAUNDER, F.R.C.S., Surgeon to the Hospital.

GENTLEMEN: By a curious coincidence a case of strangulated hernia has come under my care on the last day of each of my last three in-taking weeks. Each case has some special points of interest.

Case 1.—This was an instance of strangulated inguinal hernia of the left side, reduced *en masse* by the patient himself. I operated upon him successfully; and for the second time, with an interval of ten years.

Case 2. *Femoral hernia; operation; recovery.* (Reported by Mr. Herman Tribe.)—H. MacC——, aged fifty-eight, a blacksmith, was admitted on June 20th. 1876. Ten months ago he observed a swelling in his left groin, which sometimes disappeared. On June 17th the swelling became very hard and painful, and vomiting, which has persisted, set in. On examination to-day (June 20th) a hard, globular tumour was found at the seat of femoral hernia. There was slight impulse on coughing(?). The finger could easily be passed into the inguinal canal. The patient still vomited, appeared to be very weak, and his countenance looked haggard. An operation was considered advisable, and the man at once consented.

Published monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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The taxis was not employed by Mr. Maunder, but he opened the sac, which proved to be very thin, at once. A small quantity of turbid fluid escaped. The knuckle of intestine was portwine-coloured, slightly roughened with lymph. A very tight stricture was nicked, and the bowel reduced. The wound having been closed with suture, and a compress and bandage applied, the patient was returned to bed, and a grain of opium administered. Milk diet.

June 21st. He complains of slight pain in the abdomen, but of no tenderness. Temperature 101.5°; pulse 102. To take a grain of opium every six hours. 22d. Has slept well. There is a little redness and swelling about the wound. Lest decomposing fluids should be pent up, the sutures were removed, and the margins of the incision forcibly separated. A poultice to be applied. 23d. The redness about the wound has disappeared. The bowels are somewhat relaxed. The appetite is returning. Temperature 99.6°; pulse 96. 25th. The patient has suffered from diarrhœa since yesterday. To take chalk mixture. 26th. Diarrhœa has ceased. Wound suppurating freely. Replace the poultice by water-dressing. 27th. Diarrhœa came on again. July 6th. The patient is convalescent; the wound nearly healed. Zinc dressing. 14th. The patient is quite well, and awaits his truss.

Case 3. *Strangulated inguinal hernia; operation; recovery.* (Reported by Mr. Herman Tribe.)—Samuel S——, aged thirty-three, a builder, was admitted July 18th, 1876. Ten years ago, whilst at work, the patient ruptured himself. He had the rupture at once reduced by a surgeon. Since that time he has always been obliged to wear a truss; the hernia has never given him any trouble. On July 17th he neglected to wear his truss, and after he had been at work a little while the hernia came down. The patient attempted to reduce it, but could not do so. In about an hour's time he was compelled to leave work on account of vomiting. He went home to bed, was in great pain all night, and the vomiting persisted.

On examination a left inguino-scrotal tumour is found, pyriform in shape, tense, and painful. There is marked impulse on coughing (?). The tumour is not compressible. The patient vomits constantly.

Operation, eighteen hours after descent of hernia.—The patient having been placed under the influence of an anæsthetic, the taxis was applied for fifteen minutes, but failed to reduce the swelling. Herniotomy was then done. The structures were successively divided by a longitudinal incision over the neck of the swelling until the sac was reached. In this structure a most marked annular depression was both seen and felt, and proved to be the seat of stricture. This grooved portion of the sac was carefully divided by repeated scratches of the knife. Through the small button-hole thus formed omentum showed; and now, when the taxis was again applied, reduction was effected. The wound was closed in the usual way, and a dose of opium administered.

July 19th. The patient is very comfortable. 20th. Sutures removed. 21st. Bowels spontaneously moved. Slight suppuration with some redness and swelling about the wound, the edges of which Mr. Maunder now forcibly separated. Poultice to be applied. 24th. Redness and swelling have disappeared from the wound. Zinc ointment to be used. Aug. 1st. The patient is quite well, and is only waiting to have a truss.

With regard to Case 1—reduction *en masse*—I shall say nothing to-day, having taken every opportunity of drawing your attention to its importance when the man was in the hospital. It is published in *The Lancet* (July 28th, 1876), and can be referred to by those interested in the subject.

Case 2 is an example of femoral hernia in the male—a lesion of comparatively rare occurrence, though probably less rare than inguinal hernia in the female. Possibly, out of at least 120 herniotomies, some half-dozen of femoral in the male have fallen to my lot. In the present instance the tumour was typical, being globular in shape, seated at the upper and inner side of the base of Scarpa's triangle, whence it could not be displaced to the inner side of the spine of the pubis.

In both Cases 2 and 3 the notes say "there was impulse on coughing." To this I have added a query, as there really was none. It is desirable you should understand, in connection with hernia, the value, as a symptom, of the presence or absence of "impulse on coughing." Supposing the sac to contain bowel, with impulse on coughing, that would be proof that the contents of the intestine, both above and below the point of protrusion, directly communicated, and strangulation would not exist. The absence of impulse would show an absence of intercommunication, and that stricture existed. To avoid error, then, with regard to the presence or absence of impulse, the hernial tumour must be lifted away from the abdominal wall, when the *propulsion*—sometimes mistaken for impulse—communicated on coughing will be no longer felt, and the question of impulse settled. Imagine a patient with a hernia on either side and symptoms of strangulation. The absence of impulse on the one side and its existence on the other would materially help you to decide which to select for exploration. This method of examining a hernial tumour will prevent a very usual mistake. The local tumour and persistent vomiting in both instances led to the conclusion that we had a case of strangulated hernia to deal with, and reduction became the first consideration. This may be effected by the taxis, with or without the aid of the knife.

Question of taxis.—The taxis, a most valuable agent when judiciously applied, may, under some circumstances, be most injurious. You will have observed that I did not employ it in Case 2, but resorted to it for a quarter of an hour in Case 3. Observe the history of the two patients before they came under care. Case 2 had a history of strangulation extending over three days and three nights, and had only been ruptured ten months. Case 3, on the contrary, had been ruptured ten years, and his present symptoms extended over eighteen hours only. As a rule, the longer a person has been ruptured the larger becomes the ring, and the less quickly injurious will be its effect upon the structures which it constricts; and therefore, for the above reasons, I proceeded at once with herniotomy in Case 2, feeling pretty confident that I should not effect reduction, and that I ought to see the condition of the intestine before reducing it. With Case 3, whose hernial history was quite the reverse of Case 2, I fully expected to effect reduction by the taxis, but failed. The unyielding neck of the sac, exposed by the operation, explained the reason. Speaking generally of the taxis, I say: Use it thoroughly once only, aided by an anæsthetic if admissible, or other adjuvant: should it fail, resort to herniotomy. Even a successful taxis cannot but bruise, and that to a dangerous degree, an already much inflamed portion of bowel. This often efficient remedy can be aided by position, the trunk and limb of the patient being so placed as to favour relaxation of all the structures interested at the hernial aperture. As an illustration, I may mention that many years ago a male, the subject of femoral hernia, was under my care among the out-patients. When the patient was recumbent, and his lower extremity, of the side on which the hernia was, extended, moderate taxis failed to effect reduction; but with the thigh flexed, adducted, and rotated inwards, reduction was easy. Doubtless this facility was due to a relaxation of the upper cornu of the saphenous opening of the fascia lata.

Question of opening the sac.—This used to be a much-vexed question, but I fancy surgeons are pretty well agreed that in femoral hernia it is almost immaterial whether the sac be opened or not. Personally I avoid doing so, except under special circumstances, on the good general principle of non-interference. But in the case of an inguino-scrotal hernia I am most reluctant to open it. You will recollect how I pointed out to you the probable position of the stricture in the case of No. 3, and which coincided with the external ring. This I nicked and enlarged, but even then could not effect reduction, and it was only when I reached the sac and showed to you a deep sulcus in this that the immediate obstacle was evident. Mr. Tribe has described the care and caution which I used, and the very small wound which I made in the serous membrane, with a view to enlarge the constricting neck just enough to admit of reduction. I allowed nothing—not even the point of a director, much less my finger—to enter the sac, so as to avoid every risk of peritonitis.

The after-treatment of the wound requires some consideration. I generally close it with the hope of getting primary union, and now and then this has resulted both in hospital and in private practice. But the surgeon must be on his guard, the parts being concealed by compress and bandage, lest decomposing fluids become pent up and give rise to both local and constitutional disturbance. Should one or both arise, as occurred in these cases, the treatment is evident. Some years ago a man of seventy, from Chigwell, had been submitted to herniotomy. He progressed very favourably for several days, when, finding him drowsy and somewhat light-headed, with loss of appetite, I examined the seat of the wound, which, though healed, fluctuated. I opened it up, and gave exit to some stinking pus. A charcoal poultice was applied. On the next day all unfavourable symptoms had vanished, and the patient recovered.

Of these three patients two suffered a good deal from diarrhœa. It is reasonable to suppose that a portion of intestine injured by compression and inflammatory action would take time to recover its health. To give it rest that it may do so, we generally administer one or more doses of opium to arrest peristalsis, and administer liquid nourishment for a few days. Possibly a subacute enteritis, spreading from the damaged portion of bowel, may account for this relaxed condition. This might be prevented by a method of treatment which commends itself to my judgment, recently suggested by Mr. De Berdt Hovell. It consists in supporting the patient by nutrient enemata for a few days subsequent to operation. Certainly, by this method the small intestines would be left quiescent, and possible perforation be averted.

Your patient must not get up until provided with a suitable truss. No patient who is ruptured should be without his truss, except when he is recumbent. The danger of going without it is illustrated by Case 3. For ten years the man had not been without it, and the hernia had never given him any trouble. He omits to wear it, and becomes the subject of strangulation and herniotomy.—*Lancet*, Jan. 13, 1877.

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Cases of Paralysis of the Musculo-Spiral Nerve. By WM. R. GOWERS, M.D., Assist. Phys. to University Hospital, London.

Paralysis of the musculo-spiral nerve is of not very rare occurrence, but it is of interest from the illustration it affords of the consequences of certain forms of nerve-injury. The following cases treated at the National Hospital for the Paralyzed and Epileptic illustrate some points of practical importance in the symptomatology of the affection:—

Case 1. Paralysis of Musculo-Spiral Nerve from Pressure; Electrical Contractility of Muscles unchanged; Rapid Recovery.—A porter, aged forty-two, presented himself on January 5 with complete paralysis of the extensors of the wrist and long extensors of the fingers, of one month's duration. He had gone to sleep when lying on a bench on his right side, and woke up unable to extend the hand. Three years before, when at sea, he had had a similar attack from a similar cause, but the paralysis on that occasion lasted only three days. When first seen no improvement had occurred. No extension of the wrist or metacarpo-phalangeal joints was possible. If the proximal phalanges, however, were passively extended, the two distal joints could be readily extended by the interossei, which were unaffected. He complained of tingling in that part of the hand which is supplied by the radial division of the musculo-spiral, but no loss of sensibility could be detected. Electrical examination showed that although there was complete paralysis, there was no loss of contractility to the faradic current in any muscle except in the extensor ossis metacarpi pollicis, which did not act quite so readily as on the other side. There was no increase in contractility to the voltaic current. He was ordered faradisation of the affected muscles, and the voltaic current along the course of the nerve every other day. In a week he had recovered considerable power of extension, and the slight defect in the irritability of the extensor of the thumb could no longer be detected; and in another week he was so rapidly improving that he ceased to attend.

Case 2. *Paralysis of the Musculo-Spiral Nerve from Pressure; Change in Electrical Contractility of Muscles; Slow Recovery.*—A man, aged fifty-three, in the beginning of September, 1876, went to sleep with his arm over a sharp piece of wood, with the elbow bent. On waking he found the whole arm numb and tingling, and that he could not extend the wrist or fingers. He came to the hospital a month later, and it was then found that there was complete loss of power in all the muscles supplied by the musculo-spiral nerve, and in no others. There was marked flattening of the back of the forearm. Electrical investigation showed that, compared with the left arm, there was considerable diminution of contractility to faradism in the radial extensor of the wrist, and a slighter but distinct diminution in the ulnar extensor of the wrist and common extensor of the fingers. There was no loss of irritability in the supinator longus, but considerable diminution in the force of its contraction; a current of moderate strength caused a much stronger contraction in the supinator longus on the healthy than on the affected side. There was no loss of contractility in the lower part of the triceps, the hand muscles, or the muscles on the flexor aspect of the forearm. The muscles in which the faradic contractility was lessened presented a distinct increase in their irritability to the voltaic current. Faradisation of the affected muscles was ordered, and in a fortnight, although there was no return of voluntary power, the faradic contractility had so far returned that scarcely any difference could be detected between the muscles of the two arms, and the increased irritability to the voltaic current had disappeared. The same treatment was continued, and the improvement in contractility was soon followed by a return of voluntary power, which increased so that by the beginning of January the wrist and fingers could be extended as completely as on the other side. Both the extensors and supinators were weak, however, so that if he raised a weight from the table with the hand midway between pronation and supination, there was a tendency to increased pronation. The weakness of the extensors was shown also indirectly by the defective strength of grasp, which in the right hand was only twelve kilogrammes, while in the left it was thirty-five. The treatment was continued, however, and in another two months the arm was affirmed by the patient (and appeared) to be perfectly well.

Remarks.—The musculo-spiral nerve is of all nerves of the arm that most frequently paralyzed. This is the result of its exposed course as it winds round the humerus beneath the triceps muscle. This position exposes it to two dangers: to the effects of pressure, and to the damage in violent contractions of the triceps. The first of these is the more common, and is illustrated by the cases detailed. The position of the nerve protects it to some extent from sudden violence, but exposes it to damage from long-continued pressure, as in certain postures not unfrequently assumed during sleep. Occasionally, although rarely, paralysis results from pressure during sleep in bed. The patient goes to sleep on the right side with the arm under him, and wakes in the morning with the extensors of the wrist paralyzed. The more common cause is an afternoon nap on a chair or a bench, with the arm hanging over some hard or sharp edge. It is curious that one patient should have had two attacks produced in this way. This may have been due to some habitual position of the arm during sleep, or to the musculo-spiral nerve having a course more than usually exposed. The other way in which the nerve sometimes gets injured is by a violent muscular contraction. Dr. Gowers has seen two cases in which this occurred. One patient was an epileptic liable to attacks of *petit mal.* He felt an attack coming on, and to save himself from falling, seized a rain-water pipe close to which he was standing. On recovering consciousness he found himself still grasping the pipe, and had some difficulty in relaxing his hold, in consequence of complete loss of power over the extensors of the hand. There was at first general weakness of the limb, but it soon became limited to the muscles supplied by the musculo-spiral nerve. These rapidly wasted and presented the loss of faradic and increase of voltaic contractility. In another case the same accident happened during a violent extension of the arm in throwing a stone. There was instantly violent pain in the arm, and complete paralysis of the extensors of the wrist and fingers. A few days afterwards extravasations of blood were apparent along the edge of the biceps and also at the back over the triceps muscle. It is probable that laceration of some of the muscular fibres caused an extensive hemorrhage. In this case, a month after the injury, the faradic contractility was lost in all the muscles of the forearm supplied by the musculo-spiral nerve, and also in the lower part of the triceps muscle. The weakness of the flexors, which is conspicuous in all cases of extensor paralysis, and which was very marked in those above described, is, of course, apparent only. The flexors of the fingers, acting on both wrist and digits, can only act on the latter with force if the wrist is kept extended. Flexion of the wrist shortens so much the course of the flexor tendons that only very slight flexion of the fingers is possible. This is easily shown in the healthy. If the wrist-joint be forcibly flexed, the two distal joints of the fingers can be flexed only very slightly, and at the expense of much pain in the flexor muscles in the forearm. The constant carpal flexion on use of the hand in these cases of extensor paralysis often causes a slight backward protrusion of the carpal bones, which is the source of much uneasiness to the patient.

These cases illustrate the prognostic as well as the diagnostic value of the electrical examination of paralyzed muscles. The change in faradic contractility is an index to the state of nutrition of the nerve-fibres both within and without the muscle. The profound diminution in the faradic contractility indicates, as is well known, a degenerated state of the nerve-fibres, the result of an irritating lesion of the nerve at the seat of injury. To this the electrical contractility is the only sure guide. Visible loss of nutrition in the muscles is a less certain indication, since the flabbiness of atony may be mistaken for the shrinking of atrophy. Loss of muscular power is no guide as to the state of the nerves and muscles, as these cases show. Each came under observation a month after the injury. In each when first seen the loss of power was complete; but the first, in which there was no evidence of nerve-degeneration, was well in a few weeks; the second, in which there was marked depression of faradic contractility, was well only in a few months; while in the case of the epileptic, in whose muscles the depression of faradic contractility was profound, nine months passed before there was any return of power, although he also ultimately made a good recovery. Another point in regard to the contractility of paralyzed muscles was illustrated by Case 2. The supinator longus presented no loss of irritability; slight contraction occurred to a current of the same strength as was needed for the healthy muscle, but a stronger current caused far less contraction in the paralyzed than in the unaffected muscle. In testing a muscle the most significant thing to note is the contractility — the weakest current to which it will react; but it is also important to note the power of the muscle—the degree of contraction to a stronger current—since the latter may, in rare cases, be altered as a consequence of nerve-injury, etc., while the former remains normal. It is impossible to doubt the usefulness of electrical applications in such cases. No doubt the slighter cases would recover without its aid, but it is frequently to be noted that the first return of power occurs soon after the commencement of electrical treatment. The excitation of the nerve seems to aid the recovery of a state in which the voluntary stimulus can traverse the fibres. For this purpose, in the case of the musculo-spiral nerve, the voltaic current is most effective on account of the deep course of the nerve beneath the fibres of the triceps muscle, and the voltaic current has much greater power of penetrating a layer of muscular fibre than the faradic. The latter is, as it were, absorbed by the contracting muscular fibres to a far greater extent than the voltaic current. In more severe cases, as in that of the epileptic mentioned, in which all nerve-irritability for a time is lost, the application of the voltaic current to the muscles is often followed by an improvement in their nutrition. In that patient this was very marked, and voluntary power was ultimately regained, although it had been absent for many months, during which the muscles distinctly improved in size under the treatment.—*Med. Times and Gaz.*, May 5, 1877.

HOSPITAL NOTES AND GLEANINGS.

A Case of Placenta Prœvia; Narrow Escape from Asphyxia under Chloroform; Intra-uterine Respiration of the Fœtus.—The fact of the establishment of intra-uterine respiration in the subjoined case, which came under Dr. Galabin's care at the Guy's Hospital Lying-in Charity, has an important medico-legal as well as a clinical bearing. Post-mortem examination showed that the left lung had been sufficiently expanded by air to float in water, although the fœtus had probably died at least three hours before delivery.

For the following notes we are indebted to Mr. J. Brett, M.R.C.S., resident obstetric assistant.

On the afternoon of Feb. 12, 1877, a woman twenty-five years of age, between the seventh and eighth months of her fourth pregnancy, sent for assistance. Two weeks before she had had a fall on the left side, and the day previous she had received a blow upon the abdomen. All the morning she had been exerting herself in lifting weights, when suddenly, at 1.30 P. M., she felt a sudden gush from the vagina. At least two pints of blood were lost at this time, and the bleeding continued in lesser quantity. None had occurred previously during her pregnancy. The woman fainted from loss of blood, and was lifted into bed. When first seen she had a pulse of 130, extremely weak. No labour-pains had commenced; the os was sufficiently dilated to admit one finger; and the edge of the placenta was felt partially occupying the cervical canal. Dr. Galabin was sent for, but was not at home. The membranes were then ruptured, ergot administered, and a watch kept upon the patient. Her condition appeared so hazardous that all preparations were made for transfusion, in the expectation that this operation might become necessary before delivery could be effected.

Dr. Galabin visited the patient at 7 P. M. She had then somewhat revived, but was extremely blanched, and no uterine contractions whatever had occurred. The cervix was very rigid, and at least three inches long; the internal os was dilated enough to admit two fingers, and the external os was somewhat wider. The vertex was presenting, but was very high up, being displaced by the placenta. The placenta was still attached posteriorly up to the margin of the internal os. It was separated by the finger from the lower segment of the uterus for about two inches, according to the method recommended by Dr. Barnes, but, the uterus being perfectly flaccid, the hemorrhage was not diminished by this means, but rather increased, and the vagina repeatedly became filled with clots. It was then proposed to introduce a hydrostatic dilator into the cervix, but the patient, who was extremely restless and unmanageable, refused to allow any such manipulation without the use of chloroform. In order, therefore, to avoid more than a single administration—since an anæsthetic appeared hazardous in the patient's anæmic state—it was resolved to perform version if possible. The pulse becoming almost imperceptible before the patient was fully under chloroform, the anæsthetic was changed to ether. She then made a slight effort at vomiting, and was quickly observed to be choking. The jaws were tightly clenched, and could not be forced open till she was apparently dead. The larynx was then cleared by the finger from some vomited matter which obstructed it, and artificial respiration was performed for some minutes, after which natural breathing was restored.

Bipolar version was then performed by Dr. Galabin, the patient being in the dorsal position, and the right hand used internally. The head was already so high that its upper margin was at the level of the umbilicus, and could not be pushed much further by the internal fingers passed through the elongated cervix; it was therefore carried up to the right iliac region by the external hand acting alone, and the left knee was afterwards pushed down within reach of the finger in the cervix. Bleeding was arrested from this time, but the cervix remained too rigid to allow delivery to be completed, although ergot was again administered, and traction made upon the leg. The fœtus was then observed to make convulsive movements, and with each movement a gasping sound was heard from the uterus; this was audible at the other extremity of the small room, and upon auscultation had a startling loudness. It was evident that during version air had found its way to the fundus of the uterus, and that the fœtus, becoming asphyxiated from detachment of the placenta, was trying to breathe. The gasping was continued at intervals for about a quarter of an hour. It was impossible to effect extraction quickly, and no attempt was made to supply the fœtus with air through a tube for fear it should obtain entry into the uterine veins. If a double-action canula had been at hand, it might have been a safe measure to withdraw air by suction through it from the uterus, thus allowing fresh air to supply its place, and keep the fœtus alive until the cervix yielded. About three hours afterwards some uterine contraction commenced, four full doses of ergot having been given. The cervix gradually dilated, strong traction being made upon both legs, and the fœtus was extracted about four hours after the performance of version; it gave no sign of life. An autopsy was made, and it was evident that air had entered the lungs, the greater part of the left lung being sufficiently expanded to float in water. The fact of the intra-uterine respiration of air was thus confirmed. The mother suffered from severe febrile symptoms from the second to the fourth day, the temperature rising to 105°, and the pulse to 140; but eventually she made a good recovery.—*Lancet*, April 21, 1877.

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Removal of Naso-pharyngeal Polypus.—M. Verneuil, of La Pitié Hospital, lately removed from a boy, aged eight years, a large naso-pharyngeal polypus. The operation was attended with considerable hemorrhage; and, in consequence, symptoms of acute anæmia set in; and in the evening of the day of the operation, about four hours afterwards, the boy was so low—the temperature of the body having fallen to 33½ deg. Cent. (92.3 Fahr.)—that the *interne* on duty summoned M. Verneuil to see the patient. M. Verneuil not being at home, it was determined to keep the patient up by administering stimulants, such as brandy and water, pure claret, etc., which had the effect of producing a slight rise of the temperature. At 8 P. M., M. Verneuil, finding the patient still extremely low, at once injected hypodermically ten drops of sulphuric ether, and in about half an hour afterwards repeated the injection. From this time forward, the temperature gradually rose, and about forty hours after the operation was found to be a little above the normal standard. This case elicited some instructive remarks in a clinical lecture from M. Verneuil. In referring to syncope in connection with great operations he said that this state may occur before, during, or after an operation. In the first case, it may be brought on by simple fright, as in the celebrated case of lithotomy related by Desault, in which whilst he was describing the operation to his audience, and delineating on the patient the different steps of the operation, the latter suddenly died on the operating-table before any incision was made. Syncope during and after an operation may arise from nervous shock or from profuse hemorrhage. It sometimes happens that instead of taking place during or immediately after an operation, it may supervene some hours afterwards, which fact would point to the necessity of constant watching and nursing of the patient until he is considered out of danger. Among the remedial agents for this grave condition of syncope, transfusion has been somewhat extensively employed; but M. Verneuil is not at all partial to it under any circumstances. Indeed, he looks upon it as a most dangerous remedy, as the blood, whether of man or of animals, being of a highly putrescible character, would, even when immediate transfusion is practised, be liable to produce septicæmia, or even pyæmia. He took occasion to say that, whenever transfusion is indicated, as in syncope or excessive hemorrhage, the hypodermic injection of ether or ammonia would be preferable to transfusion of blood or any other liquid, even in puerperal or *post-partum* hemorrhage.—*British Med. Journal,* March 31, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Administration of Cod-Liver Oil in Malt Extract.—At a recent meeting of the Norfolk District Medical Society, Prof. Markoe (*Boston Med. and Surg. Journ.*, May 3, 1877) called attention to malt extract as an emulsive agent for cod-liver oils and other oleaginous preparations. At the present time, when cod-liver oil is extensively employed as a therapeutic agent, anything that will neutralize or overcome its disagreeable oily character and bad taste will be welcomed by patients. Extract of malt possesses the power of producing a perfect emulsion with cod-liver oil, and a mixture of equal parts of cod-liver oil and extraot of malt was exhibited, having a semi-solid consistence, in which the taste of the cod-liver oil was more perfectly concealed than can be accomplished by any other known process. Other mixtures were also shown containing various proportions of cod-liver oil, and to which various flavoring extracts had been added.

Death during Etherization.—Dr. Benjamin W. Robinson, of Fayetteville, N. C., reports (*Virginia Med. Monthly,* April, 1877) the case of Mrs. McNeil, who consulted him on account of a tumour of the breast, which he extirpated while the patient was under the influence of ether. The tumour returned, and the operation was repeated in ten months. Again after the lapse of six months, a third operation was performed, and Squibb's ether was administered in a conical inhaler. During the inhalation the pulse improved in volume and force. In about twenty minutes after the operation was begun, it was announced that, with gradually increasing pallour, the radial and temporal pulse, which had been failing since the operation began, were extinct, and that the respiration was irregular. Brandy was administered subcutaneously, the foot of the operating table raised, and artificial respiration practised. The lapse of a few minutes promised thorough resuscitation, the patient became conscious, the horizontal posture was restored, and the operation was continued without the inhalation of any more ether. In a few minutes the patient vomited, after which it was found that she was sinking. All efforts at resuscitation now proved unavailing. A post-mortem examination appears not to have been made, but the history of the case leads to the suspicion that death was caused by the trachea becoming choked up with vomited matter.

Deaths from Chloroform.—Dr. Charles Anderson records (*Clinic,* March 31, 1877) over twenty cases of death from chloroform which have occurred in Cincinnati and its vicinity within the last thirty years. Some of these were not previously recorded.

In the *American Journal of Dental Science,* May, 1877, is reported the death of Dr. Chas. A. Jourdan, caused by the inhalation of chloroform prior to the extirpation of his eye.

The American Medical Association.—The meetings of the Association for some years past, even its most ardent supporters must admit, have not produced the results which should follow from the gathering together of so many able and practical members of the profession. The late International Medical Congress has demonstrated what can be done with the same material, for the most part, under a good plan of organization, with an intelligent arrangement of details, and we trust that the example which it gave will not be lost upon the Association.

We have not seen the programme prepared by the Committee of Arrangements for the ensuing meeting, but trust that it embraces as many as possible of those elements which did much to insure the pre-eminent success of the late Congress at Philadelphia. Judging from the experience of last September, we think every delegate will agree with us in saying that it is very desirable that a detailed programme be published in advance of the meeting, giving the work for each day and hour; that all the Sections meet under the same roof; that a lunch be provided in the building where the meeting is held, so that the members may be kept together the entire day; that a list of delegates registered up to date be published daily; and that the social aspect of the meeting, although an important feature, be kept strictly subsidiary to the scientific work.

At this session of the Association we hope a plan for the future will be devised by which the scientific character of the meetings may be promoted hereafter, and their value enhanced. As tending to the accomplishment of such an aim we would suggest that the general meetings should be solely devoted to the reading of the addresses already provided for, to the reception and action upon the reports from the various Sections communicating the results of their scientific labours, and to such business as may be brought before the Association by the Judicial Council, to which Council all motions relating to private business should be first referred without debate. The meetings of the Sections should be devoted to the consideration of scientific subjects determined upon beforehand, the discussion of which would be opened by reporters, and outlines of whose remarks should be published at least three months in advance of the meeting, so as to promote intelligent debate. The conclusions of the Sections upon the topics discussed could be ascertained by vote, and reported to the Association in general meeting. Provision ought also to be made for the reading and discussion of volunteer papers.

Such changes as are above indicated would, we think, undoubtedly result greatly to the advantage of the Association.

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The Association and the Pharmacopœia.—In an able paper read before the Philadelphia College of Pharmacy (*American Journal of Pharmacy*, May, 1877), Mr. Alfred B. Taylor discusses Dr. Squibb's propositions for the seizure by the American Medical Association of the Pharmacopœia of the United States; and he particularly calls attention to that part of the plan for the future revision of the Pharmaeopœia, which in Dr. Squibb's opinion is to insure to it a thoroughly *national* character. "The plan which is to be submitted to the American Medical Association, at its meeting in June next, is that it shall organize a Pharmacopœial Council, to be incorporated if necessary, consisting of five members, which council shall be charged with the *entire management* of the Pharmacopœia and all that pertains to it, and be responsible only to the American Medical Association. This council I would propose to form as follows: The nominating committee of the Association to nominate and the Association to elect the president of the council; then the Association to *invite* the surgeon-generals of the army and navy each to appoint one member, and *invite* the American Pharmaceutical Association to appoint two members." (Dr. Squibb's pamphlet, p. 25.) Now for the *modus operandi*. "As the meetings of this council would have to be frequent during the general revisions, and perhaps two or three times a year for the supplementary fasciculi, and as the members would have to educate themselves to the special work, it would, perhaps, be better that the council should be small and compact, and live in adjacent cities." (*Ibid.* p. 9.) As three of the council are to constitute a *quorum* (*Ibid.* p. 54), who may "obtain a change in any of its members," we should probably have, as the final outcome of the so-much-vaunted "nationality" of the enterprise, a pharmacopœia under the entire control of *three representatives of the United States* (small and compact), "living in immediately adjacent cities!" And this is gravely proposed as an eminently "national" improvement on the existing *local* plan of an executive committee of *fifteen*, representing *nine* leading cities, from Boston to Richmond, and from New York to San Francisco, together with a representative of the army and of the navy of the United States.

At a recent special meeting of the Philadelphia County Medical Society held to consider Dr. Squibb's proposition, Dr. Albert H. Smith presented the following resolutions, which were unanimously adopted:—

Resolved, That this Society does not recognize the legal or moral right of the American Medical Association to assume the work of issuing a Pharmacopœia as proposed, nor its fitness for the work, if such right existed.

Resolved, That its delegates to the American Medical Association be instructed to use every proper means, by their votes and influence, to prevent the consummation of the plan proposed by Dr. Squibb.

The following resolutions, offered by Dr. Nebinger, were also adopted:—

Resolved, That in the opinion of the Philadelphia County Medical Society, the propositions of Dr. Squibb to modify the *period* of revision of the United States Pharmacopœia and other proposed reforms, are deserving of careful consideration by the medical and pharmaceutical professions.

Resolved, That in the judgment of this Society, such reforms and modifications of ancient plans can be more safely entrusted to the National Convention for the revision of the Pharmacopœia and its committee of revision, than to any new organization.

Resolved, That the action of this Society be officially transmitted to Dr. John C. Riley, President of the Pharmacopœial Convention at Washington, to Dr. Bowditch, President of the American Medical Association at Chicago, and to Dr. Squibb of Brooklyn.

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Medical and Chirurgical Faculty of Maryland.—The 79th annual session of this Association was convened at Baltimore, on April 11th, Dr. Christopher Johnson, president, in the chair. The following officers were elected for the ensuing year: President, A. B. Arnold, M.D. Vice Presidents, Drs. S. C. Chew, Ferdinand Chatard, and Charles H. Jones. Secretary, Dr. W. G. Regester.

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Mississippi State Medical Association.—The tenth annual meeting was held in Grenada, on April 4th, Dr. P. J. McCormick, president, in the chair. The following officers were elected for the ensuing year: President, Dr. B. A. Vaughan, of Columbus. Vice-Presidents, Dr. E. W. Hughes, of Grenada, T. R. Trotter, of Duck Hill, T. P. Lockwood, of Crystal Springs, and J. T. Parker, of Buena Vista. Secretary, Dr. Wirt Johnson, of Jackson. The next meeting will be held at Jackson, on the third Wednesday in January, 1878.

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Texas State Medical Association.—The annual meeting of this Society was held at Galveston on April 3d, Dr. B. H. Harrison, of Columbus, president, in the chair. The following officers were elected for the ensuing year: President, Dr. Kelley, of Galveston; Vice-Presidents, Drs. Cupples, of San Antonio, Swearinger, of Austin, Sayers, of Waco; Treasurer, Dr. Achison, of Denison. The next meeting will be held in San Antonio on the first Tuesday in April, 1878.

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Changes in the Regulations of the Medical Department of the University of Pennsylvania.—At a special meeting of the Board of Trustees of the University held on the 15th of May, it was resolved that hereafter all students shall be required to attend three annual courses of lectures of five months each, each course to be so graded as to prepare the student for the studies of the next. At the close of each annual course, examinations on the studies will be held to test the student's fitness to pass on to the next course. The above arrangement of studies will enable the third year to be devoted chiefly to the study of practical branches, and it is proposed to teach these "in a more thorough way than has ever been done in America." There will be no preliminary examination for admission. The fees will be $140 for the first and second years each as heretofore, and $100 for the third year. The above changes will not affect in the least the status of the present matriculants of the school, who can complete their studies and graduate upon the old plan, unless they elect voluntarily to pursue the new course. The professors will hereafter be paid salaries, so as to be independent of the size of the classes.

This system is substituted for the present two-years course of lectures which, as now delivered, are identically the same each year; and it introduces into medical study the system which is pursued in all other forms of study.

To successfully carry out these efforts to give a better education, which has been demanded by the profession in one form or another for the last thirty years, it is needless to say that a large endowment fund is necessary, and for it the Trustees confidently look to the friends of the University. Already a number of the citizens of Philadelphia have liberally come forward and have guaranteed for several years the University against any pecuniary loss which may result from the temporary diminution in the size of the classes which, it is thought, may for a few years follow upon the adoption of the improved curriculum; and we trust that the profession at large will be equally prompt in giving their sympathy and support to this commendable effort to elevate the standard of medical education in this country.

Harvard University.—Dr. John P. Reynolds has been appointed to the Chair of Obstetrics at the Harvard Medical School, left vacant by the death of Dr. Buckingham.

Changes in the Philadelphia Medical Schools.—Dr. Robert E. Rogers has been elected to the Chair of Medical Chemistry and Jurisprudence in the Jefferson Medical College. Dr. John Neill has resigned the Chair of Clinical Surgery in the University of Pennsylvania.

Maryland Medical Journal.—The first number of this periodical was published at Baltimore on May 1. It is an octavo of 36 pages, under the editorial and business control of Drs. H. E. T. Manning and T. A. Ashby. It contains four original articles, and editorials and selections. In placing it on our exchange list, we cordially wish it all success.

Homes for the Reformation of Intemperate Women. — Various attempts have been made to establish reformatories for drunken women, but heretofore all have failed to accomplish any encouraging results, and a few years have witnessed their closure. The class of cases received has not been permanently impressed, and the one most likely to be reformed has not been induced to submit their cases for treatment. The "snuff-chewing sisterhood" compose about 80 per cent. of the applicants; and experience teaches that their drunkenness is so interwoven with other vices, that it is next to impossible to reform them. But there is a class of cases in all our large cities that ought to be reached, and that might be benefited, but as yet they have not been; we refer to those in the higher walks of life, who by birth, education, and general deportment, are, when sober, recognized as ladies. They have not been reached, for the following reasons, viz.: 1. Female reformatories cannot be conducted as those for men. Publicity is a great obstacle to the former, but a benefit to the latter. 2. Secrecy rules to a large extent in the drinking of women; and the more public it becomes, the less hope is there for reformation, if received into a home. Shame has a great influence, and treatment must be made as free from the eye of the public as possible. 3. A mixed company is rather an advantage in a home for men, but ruinous to success in one for women, as they will not subject themselves to the risks of subsequent forced association or recognition on the part of objectionable acquaintances made while under treatment.

To carry out these views, a home has been opened by a society of ladies in a neatly furnished house at No. 220 North 13th Street, Philadelphia, designed exclusively for the class mentioned. The passer-by only sees what is apparently a private dwelling; but within are all the appointments of a small, well-ordered public institution, having its Matron, Board of Managers, etc. Privacy is the order of the house; and the inmates, it is hoped, will be secured through the medical profession, and their friends or relatives. Although in these cases moral restraint is generally required rather than medical treatment, yet the latter, when necessary, will be here administered under the supervision of Dr. Robert P. Harris.

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Obituary Record.—At Philadelphia, on April 12, Jonathan M. Foltz, M.D., late Surgeon-General U. S. N., aged 67 years.

Dr. Foltz was born in Lancaster County, Pennsylvania, and studied medicine at Jefferson Medical College, in this city, where he graduated in 1830. He was commissioned assistant surgeon in the navy April 4, 1831, and was ordered to the frigate Potomac, in which vessel he made a voyage around the world. He served on various American ships of war, and was surgeon on the fleet sent to the Gulf of Mexico during the war with Mexico. During the rebellion, he served on the frigate Santee, and was under Admiral Farragut in all his operations on the Mississippi River and at Mobile. He was a member of the Board of Medical Examiners, from 1864 to 1867. In 1870, he was made President of the Naval Medical Board. In 1871, he was appointed Chief of the Bureau of Medicine and Surgery, with the rank of Commodore, and was retired in 1872, after forty-two years of active service.

FOREIGN INTELLIGENCE.

Treatment of Ovarian Hysteria.—The correspondent of the *Lancet* in describing a visit to the Hospice de le Salpétrière makes the following report of Prof. Charcot's treatment of hysteria:—

We had the opportunity of seeing Dr. Charcot apply his method of stopping a fit instantaneously in women affected with "ovarian hysteria." Two women fell into a fit, and Dr Charcot by applying pressure with the hands to the diseased ovary arrested the paroxysm almost immediately.

Dr. Bourneville, who accompanied me on my visit, spoke of the various new substances which he is now trying under the direction of Dr. Charcot in cases of nervous disease, and especially of nitrite of amyl, bromide of camphor, bromide of sodium, and bromide of zinc. He is still very well satisfied with the effects of bromide of camphor since his first researches on the drug. It is administered largely at La Salpétrière, in the form either of Clin's capsules or of enemata. In a great number of epileptic cases it has been found to diminish the vertigo most notably, and to diminish in a good many cases the number of fits. It has rendered considerable service in the delirium which follows the fits in epileptic mania, and has proved very useful in hysteria. I have been promised Dr. Bourneville's observations on the other drugs I have mentioned. I cannot conclude, however, without remarking that the hydropathic and bathing arrangements of such a large and special establishment as La Salpétrière seem scanty and insufficient. This part of the hospital arrangements is so very important in the treatment of nervous affections that it is strange that the Assistance Publique does not understand the good, and even the saving, that would result from greater liberality in the supply of baths.—*Lancet*, April 14, 1877.

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Administering Iodine through a Nurse.—Dr. Gemmel, of Birnbaum, relates (*Berlin. Klin. Woch.*, April 9) the case of a feeble, rickety child a year and eight months old, to whom it was thought of great importance that iodine should be administered, which, however, in any form tried, had induced vomiting and irregular action of the bowels. It was then resolved to try giving it through the milk of a nurse, and in a few days after she had begun taking it her milk was sufficiently impregnated with it. It was found also that a cow's milk could be similarly affected by giving the animal ten grammes of iodide of potassium per diem for a fortnight. The child under the use of the nurse's milk bore the iodide very well and soon recovered.—*Med. Times and Gaz.*, April 28, 1877.

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Death during Anæsthesia.—Anæsthesia was induced in a female, aged 21, who was to undergo amputation of the leg at Westminster Hospital, London. Chloroform to the extent of two drachms was given on lint, and the patient quietly and quickly became insensible; then ether, poured upon a sponge placed in a felt cone, was substituted for the chloroform. Meanwhile, Esmarch's bandage had been applied to the limb above the gangrenous part, and the band secured at the lower part of the thigh. The patient then became blue in the face and pulseless at the wrist; the lips were white, and the heart's action could not be felt. Artificial respiration was immediately begun, and the bandage and band were removed from the limb. In spite, however, of all attempts at resuscitation, which were continued for fifty minutes and which included cold affusion, flipping with towels, and the application of the interrupted current to the præcordium, the heart failed to beat again. The pupils were equally contracted throughout these attempts. The amount of ether used was two ounces, and the patient was moribund in about two minutes after the ether was begun. The chloroform was given by itself for about three or four minutes, and ether by itself for about two or three minutes. At the *post-mortem* examination, the surface of the heart showed friction-patches, but no signs of pericarditis. The wall of the right ventricle was very thin; that of the left side was thicker than usual, pale in colour, but not unusually soft. The mitral valves were much thickened, the chordæ tendineæ thickened, and the musculi papillares hypertrophied. At the junction of the anterior cusp of the mitral valve with the wall of the ventricle was an irregular ulcerated patch about as large as a silver sixpenny-piece, to which small masses of lymph were adherent. The aortic valves were thickened, but acted efficiently. Two large decolorized clots were found in the left ventricle.—*British Medical Journal*, March 31, 1877.

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Daltonism and Navigation.—In the *Lyon Médical* for January 21, Dr. Favre, who is well known as an authority on colour-blindness, urges the necessity for a systematic examination of sailors in that respect. After much inquiry, he has found that the subject has been hitherto overlooked, and, with others who are favourably placed for judging, he agrees in the opinion that many of the disastrous collisions at sea, which occur principally at night, are due to a false perception of the colours of the lights used as signals.

Dr. Favre quotes from a recent paper by M. Féris, in proof of the fact that colour-blindness exists among the sailors of the French navy. M. Féris examined 501 sailors at Lorient, and found that 47, or about 9.4 per cent., were wanting in the accurate perception of colour. He also examined 152 men on board the *Hamelin*, and found 18, or 11.83 per cent., affected. These were not all equally faulty, and M. Féris adopted a classification which may be a useful guide to future investigators. 1. Those who hesitated in distinguishing colours, of whom there were 5. 2. Those who confused slight shades of different colours, as pale blue for green, 2 in number. 3. Decidedly colour-blind; (*a*) confusing blue and violet, of whom there were 6; (*b*) confusing both blue and violet, and also red and green, of whom there were 4.

Dr. Favre concludes his paper with some very forcible remarks on the necessity which such results show for a systematic examination of the eyes of those following maritime occupations.—*London Med. Record*, March 15, 1877.

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International Medical Congress, Geneva, 1877.—The International Medical Congress will be opened at Geneva, on the

9th of September, under the auspices of the Swiss Federal Council and of the Canton and City of Geneva; and will remain in session the entire week. It will be composed of delegates from medical societies, foreign and local. Members only will have the right to participate in the proceeding of the Congress. The sessions will be held at the University. The registration book will be opened on the 8th of September, from noon until 5 o'clock.

The Congress will meet daily, first in sections, and afterwards in general meeting. The conclusions of the sections on the subjects designated for discussion will be reported to the Congress in general meeting. The general meetings will be devoted to the reception of the reports from sections, and, if desired, to their discussion; and to conferences or to reading of communications upon subjects of general interest.

Delegates desiring to make communications upon subjects not on the programme are requested to notify the committee at least 15 days before the opening of the Congress. The time allotted to each speaker is twenty minutes. The French will be the language of the Congress, but members may speak in any language.

The following preliminary programme for the various sections gives the topics for discussion, with the names of the reporters thereon:—

Section I. *Medicine.*—1. Ulcerations of the Stomach. Prof. Lebert. 2. Parasitic Affections of the Skin. Dr. Hardy. 3. Etiology of Typhoid Fever. Dr. Bouchard. 4. Treatment of Fever by Baths. Dr. De Cévenville. 5. On the Different Tissues found in the Organism, Dr. Zahn. 6. Indications and Therapeutic Value of Tracheotomy in Croup. Dr. Revilliod. 7. Universal Pharmacopœia. Prof. Gille.

Section II. *Surgery.* — 1. Bloodless Method of Esmarch. Dr. Esmarch. 2. Influence of Wounds upon Pregnancy. Dr. Verneuil. 3. Treatment of Ozœna. Dr. Rouge. 4. Results of Articular Resections. Dr. Ollier. 5. Galvano-cautery. Dr. Julliard. 6. Means of Transportation for Wounded. 7. Urethral Fistulæ. Dr. Reverdin.

Section III. *Midwifery and Gynæcology.* —1. Placental Souffle. Dr. Rapin. 2. Artificial Feeding of Infants in the First Year. Dr. Zweifel. 3. Anæsthesia during Labour. Dr. Piachaud. 4. On the Law of Growth of Infants in their First Year, and of the Physiological and Pathological Deviations. Dr. Odier. 5. Pseudo-membranous Dysmenorrhœa. Dr. Gautier.

Section IV. *Public Medicine.*—1. Influence of Alcoholism on Mental Diseases. Dr. Magnan. 2. Influence of Adulterations of Alcoholic Liquors upon the Health of those who make and consume them. Dr. Guillaume. 3. Questions in Medical Geography. Dr. Lombard. 4. Influence of Immigration from the Country to the Cities. Dr. Dunant.

Section V. *Biology.*—1. Physical Characters of the Electric Discharge of the Torpedo. Physiological Analogies of this Discharge with Muscular Contractions. Dr. Marey. 2. Cerebral Localization. Dr. Broadbent. 3. Cause of Sleep. Dr. Preyer. 4. The Entozoa of Man. Dr. Vogt. 5. Functions of the Spleen. Dr. Schiff. 6. Histology of the Ovum and rôle of the Zoosperm in Fecundation. Dr. Fol. 7. Physiological Antagonism. Dr. Prevost.

Section VI. *Ophthalmology, etc.* — 1. Indications for the Enucleation of the Globe of the Eye in cases of Sympathetic Ophthalmia. Dr. Warloment. 2. Etiology and Prophylaxis of Myopia. Dr. Haltenhoff. 3. What are the best Methods for determining the State of the Principal Functions of the Visual Organ? (*a*) acuteness of vision; (*b*) perception of colours; (*c*) refraction and accommodation; (*d*) visual field (indirect vision); (*e*) mobility of the eyes. Dr. Fol. 4. Tenotomy of the Tensor Tympani. Dr. Colladon.

During the Congress, there will be held an exposition of apparatus or new instruments used in medicine, surgery, physiology, etc.

All communications relative to the Congress should be addressed to the Secretary General, Dr. Prevost, 8 Rue Eynard, Geneva.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Cases of Exostosis upon the first Rib. Delivered at the Middlesex Hospital. By JOHN W. HULKE, F.R.C.S., Surgeon to the Hospital.

There are, gentlemen, now in the hospital two cases of a rather rare disease—exostosis upon the first rib; one under my care in Regent ward, the other under the care of Dr. Thompson, who kindly allows me to refer to it. I shall also read to you notes of a third case under my care in 1873.

Case 1.—A plump and well-grown girl, aged fifteen, with auburn hair, and a remarkably demure, placid expression of features, living at home, was admitted on October 24, complaining of weakness and painfulness of the left arm, increased by exertion, and attributed by her to a knob in the root of the neck at the left side. This seemed to be about as large as a walnut. It was deeply placed behind the inner half of the collar-bone, which overlapped and partially hid it. It was quite fixed, not following the movements of the collar-bone, nor swayed during extreme bending of the neck. Its bony attachment was beyond doubt the outer surface of the first rib. The subclavian artery, lifted by it out of its usual position, crossed the front of the knob below its summit; the pulsations of the vessel were visible, and very slight pressure

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upon it backwards against the knob sufficed to stop the wrist-pulse. A couple of cords, which, from their direction and figure, as also from the pain produced by pressure upon them, were obviously part of the brachial plexus, crossed the summit of the knob from above downwards and outwards. Crossing these cords and the top of the knob from before backwards as if coming from the third part of the subclavian artery, was a smaller pulsating vessel, presumably the arteria transversalis colli. The inner part of the knob was crossed from above downwards and forwards by a muscular band—the outer border of the musculus scalenus anticus — which hid its innermost limit, whilst its outer border reached nearly to the anterior margin of the musculus trapezius. These were the objective symptoms. The subjective were alleged numbness and painfulness, chiefly in the outer and back parts of the shoulder, arm, and forearm, in the distribution of the circumflex and external cutaneous branches of the musculo-spiral nerve. The pain was not constant; its intensity varied. The tactile sensitiveness of these parts was not found to be less than that of the corresponding parts of the right limb. She had, she said, a want of power in the left limb, but its strength, roughly tested by bidding her squeeze both my hands with her own, showed no diminution, and careful comparative measurements of the arms did not show any wasting of the left, the muscles of which certainly felt as firm as those of the right arm. Sphygmographic tracings of the two wrist-pulses did not show any difference of the left. She slept well and ate well, and her general appearance and manner were not those of a person in constant pain.

The painfulness of the arm began, she said, about eighteen months before, and some four months later she first discovered the knob in her neck. It was then as large, she thought, as at the date of her admission into the hospital.

The extreme hardness, the fixity, the nodular figure, the definite outline, the slow growth of the knob, and the age of the patient, concurred to place its nature beyond dispute; it was obviously an *exostosis*, and it sprang from the first rib.

The next case is so similar that I will read it before commenting upon the first:—

Case 2.—A well-grown, rather thin, but healthy-looking blonde, aged twenty, was admitted into Regent ward, March 6, 1873, with a knob in the right side of the root of the neck, rising visibly above the middle third of the collar-bone. Its hardness was that of bone. It was fixed to the first rib. The subclavian artery crossed the front of the knob just below its summit, lying almost subcutaneously on it, so that its pulsations were very apparent. The right radial pulse was smaller and weaker than the left. Behind the artery, rounded cords crossed the summit of the knob in a downward and outward course; their form and the tenderness felt when pressure was made upon them proved them to be part of the brachial plexus. The front border of the musculus trapezius overlapped and concealed the outer border of the knob, and the highest part of the knob was crossed from before backwards by an artery much smaller than the subclavian, from which it seemed to spring—probably the arteria transversalis colli. The outline and figure of the knob were even, smooth, nodular, and very definite.

She had, she said, first become aware of the existence of the knob two years before, happening to feel it whilst washing herself; her attention was not drawn to it by any pain or discomfort. About five months ago her arm was accidentally twisted backwards behind her with some force. From that time she had been liable to twinging pain in the right side of the chest and shoulder, and her impression was that since this accident the knob had grown a little larger.

This case had been mistaken upon a superficial examination for an aneurism of the subclavian artery.

Case 3.—The general features of the exostosis in Dr. Thompson's patient are so similar that a detailed description is scarcely necessary. She too is a girl, nineteen years old, with a pale complexion, and rather worn face. She is under treatment for a gastric ulcer. The exostosis is on the left side. It springs from the outer surface of the first rib; its lower part is hidden by the collar-bone, and the musculus scalenus anticus and musculus trapezius overlap respectively its anterior and posterior borders. The brachial artery lies upon its front, lifted well above the collar-bone, and its summit is crossed by cords of the brachial plexus. She complains of weakness and painfulness of the limb; the latter she generally, but not constantly, refers to the distribution of the circumflex and musculo-spiral nerves.

Probably the first thing, gentlemen, that will have struck you on hearing these cases is that the patients are all three women. Two others which I have seen were also women; and Mr. Hilton and Sir William Fergusson, who have each seen some three or four cases, have verbally informed me that these, too, were all of the female sex. No example of exostosis of the first rib in the male sex has yet come under my observation; but it may well be that with larger numbers this preponderance of women may cease. I have not seen any statistics of exostosis upon the long bones of the limbs bearing upon the liability of the two sexes; but the impression I have formed from my own experience is that here the liability is pretty evenly shared by both. Another peculiarity is that in all these cases the exostosis was single, whereas in the limbs exostoses are so often multiple. Mr. Clarke had, some time ago, in Bird ward, a young girl about twelve years old, with some half-dozen exostoses on her legs and arms; and similar examples of this multiplicity are by no means uncommon.

With respect to their etiology, all we can say is (and this guardedly) that sex seems a favouring condition, as youthfulness is certainly, for this exostosis as for those upon the limb-bones. The three patients whose cases I have described were respectively fifteen, twenty, and nineteen years old, and the exostosis was known to have existed one and a half, two, and three years respectively when the patients first came under observation. These patients were not the subjects of any particular diathesis; they seemed, excepting the third, to be in perfect health. The third patient's health is not good; her impaired general nutrition is probably attributable to the stomach ulcer. With regard to the occurrence of any local exciting cause—*e. g.*, a mechanical injury—the part of the rib from which the exostosis springs is so protected by the collar-bone that no blow can reach it. The last patient attributed the knob to injuries received by being thrown down and trampled on by a mob on the Thanksgiving Day for the Prince of Wales's recovery, but on questioning her it was elicited that the only part of her chest which felt sore from these bruises was the "pit of the stomach," and no bruise was visible here or elsewhere, so that I think the idea of an injury to the rib from this accident cannot be seriously entertained. I am not aware of any published descriptions of exostosis on the first rib or of operations for their removal, in the absence of which the exact point from which these exostoses usually spring is unknown to me, but it cannot be far from the tubercle at the insertion of the scalenus anticus muscle, and in this respect the costal exostosis resembles the common exostosis at the lower end of the inner femoral condyle, which is usually rooted in the neighbourhood of the insertion of the long tendon of the adductor magnus muscle. This similarity suggests that under some circumstances, yet unknown to us, excessive tensions of the bone and periosteum by inserted muscles may provoke a bony outgrowth in these situations. The formation of bony rays in the fibrous attachments of the adductor muscles to the pelvis, which has been often observed in men who pass much of their lives in the saddle, lends support to this supposition. It must not be overlooked that, as regards the femur, the epiphysial plate of cartilage lies in the level of the root of the exostosis, and is still unossified at the age when these exostoses occur.

As regards treatment, it will generally be prudent to advise palliative measures only—as a sling, to take off the drag of the limb, and the avoidance of all unnecessary efforts. Bearing in mind the important structures in close relation to the exostosis—the subclavian artery, brachial cords, and the pleura (which, as you are all aware, rises above the level of the rib)—I have not, in any of the cases I have yet seen, felt justified in recommending excision; for I think that nothing short of very decided pain and disability of limb would warrant the patient in exposing her life to the not inconsiderable risks which even the best conceived and best executed operation must entail. In the case in Regent ward in March, 1873, the question of an operation was not seriously discussed, because the woman entered the hospital with a fixed determination not to be cut. In our first case the girl's statement of her pains and numbness, and of the disability of the limb, are, I am disposed to think, somewhat overdrawn; but as her assertions are very positive and unvarying, I have placed her position fairly before her and her mother, telling her that whilst I could not propose the removal of the knob, I would not decline if they desired me to undertake it. They have, as I think wisely, decided to defer an operation for the present. Were an operation undertaken, I should fear to use a bone-forceps or chisel, knowing the textural change which the parent bone often has undergone about the root of an exostosis, weakening it, and having in mind the comparative thinness of such a bone as a rib—although the first rib, especially its inner border, is comparatively strong. I should fear that the jarring, which is unavoidable in using these instruments, might splinter the rib and leave a rough surface, for smooth cutting with the chisel requires the tissue to offer a certain resistance, to be kept perfectly steady, and to have enough bulk to absorb the most of the momentum of the blow. The division of the neck of the exostosis with these implements must also necessarily be made from without inwards, by which direction the risk of injury of the pleura would be greater. My idea would be to expose the surface of the knob where it is uncovered by the large artery and nerve-cords, to divide the capsule of condensed cellular tissue which usually sheathes such tumours, and to push back with a blunt raspatory this, and with it all structures in juxtaposition with the knob, until its neck was so far exposed that a fine chain-saw could be looped round it, with which it could be cut through from within outwards, leaving a perfectly smooth bony surface without any asperities which would damage the artery and nerves, and without any dangerous jarring. I am, however, bound to tell you that, being ignorant, as we necessarily are, of the size and extent of the attachment of the exostosis—whether it reached far inwards round the inner border of the rib—the practicability of thus sawing it off, and indeed of removing it in any way, could only be ascertained in the course of the operation.—*Med. Times and Gaz.*, Feb. 24, 1877.

HOSPITAL NOTES AND GLEANINGS.

Notes of Practice at the St. Bartholomew's Hospital.

Intestinal Obstruction.—A bricklayer, aged 29, had been healthy till his present illness, which commenced three weeks previously to admission with severe constipation and vomiting of food. He had taken several doses of castor oil and drastic purgatives before coming to the hospital; the bowels were, however, very slightly moved thereby. A very small amount of feculent matter was passed, but "much blood and slime." The vomiting was attended by great abdominal pain, and became bilious, but unattended with feculent matter. He had been able to take but very little nourishment, was somewhat emaciated, and greatly prostrated. On admission, the abdomen was distended and painful; the central portion hard and prominent; the flanks hollow and tympanitic, indicating an empty condition of the colon and a loaded state of the small intestines, probably depending upon obstruction near the ileo-cæcal valve. The glands in the axillæ and groins were enlarged. There was some loss of flesh; and his general appearance suggested the presence of abdominal cancer as not improbable. Temperature 98.4 deg. There was no history or any likelihood of lead-poisoning. He was ordered a hot bath and subcutaneous injections of morphia. In a few hours the vomiting ceased; he began to pass copious loose motions, and within two days was free of all pain and abdominal tenderness, and the tongue cleaned spontaneously. No purgative or other medicine was given.

Dr. Southey then narrated the case of a young woman who had been attacked three days before, on board ship, with great abdominal pain, complete obstruction of the bowels, and vomiting becoming fecal. She had been treated by the ship's captain with ten grains of calomel and one scruple of jalap powder every two hours. This occurred during a menstrual period, and suggested possible obstruction from pelvic hæmatocele; examination, however, did not confirm this idea. She was evidently very ill. The rectum was emptied by enemata; no obstruction could be felt by the finger; the loins were hollow and resonant, and the hypogastrium hard, indicating an empty colon and loaded small intestines. The long tube was then passed, but was soon arrested by an obstruction (very probably the promontory of the sacrum); only a little fluid could be injected, and that caused great pain. It was proposed to the patient to administer chloroform before proceeding further, but she declined it. The question of abdominal section was proposed, but it was decided to try the following plan first. The patient was placed in the genu-pectoral position, the tube again inserted, and the anus held closely around it. A siphon bottle of soda-water was then connected with the tube, the bottle being placed in hot water to increase the elasticity of the gas contained in it. On opening the valve of the bottle, and allowing the gas and water to ascend into the rectum, enormous abdominal distension and severe pain resulted. Two siphons of soda-water were thus used. The patient then felt "something give way or burst," and copious action of the bowels followed. Probably some band of adhesion gave way, or a twisted portion of intestine was unfolded. In two days the patient was well enough to undertake a journey. No medicine was used, except subcutaneous injections of morphia. The plan was recommended two years ago in one of the French reviews, and it seemed preferable to the simple injection of fluid, the elastic gas forcing its way more easily than fluid would do.

Rheumatic Fever. — Dr. Southey frequently uses salicylic acid after the first week of the fever, giving ten-grain doses, dissolved in liquor ammoniæ acetatis every two hours, to twelve doses, and then every four hours, or according to the symptomatic indications, but producing slight physiological effects, as noises in the head, etc. Dr. Southey is of opinion that this mode of treatment reduces the temperature, lessens arthritis, and renders the patient less sensitive to the pain; not, however, preventing endocarditis or other complications. In *pericarditis,* it was pointed out that an amount of effusion, not causing perceptible increase of præcordial dulness, may almost always be detected by an increase in the rapidity of respiration.

Intracranial Syphilis.—A man, aged 37, complained of severe and continuous pain in the head. He was in hospital last January with weakness of the left arm, leg, and of the facial muscles, and paralysis of the external rectus of the right eye. Syphilis being suspected, iodide of potassium was given in large doses, with the result of apparent cure. He has returned with great weakness of both legs, so that "his body seems too heavy for him." In going up stairs, there is great difficulty, and he complains of pain in his legs. The tibiæ are somewhat tender, and the muscles rather wasted. He also complains of constant pain in the left side of his head, worse at night or on any movement. The power of taste is lost (glosso-pharyngeal nerve), but the perception of bitters and acids is retained (gustatory). Pus is seen coming from above the palate, probably from the posterior portion of the nasal bones being diseased. His nights are restless, and digestion is indifferent. He was ordered fifteen grains of iodide of potassium three times a day, and two drachms of Carlsbad salt in hot water every morning.

OUT-PATIENT DEPARTMENT (DR. DUCKWORTH).

Diabetes Insipidus.—A healthy looking man, aged 53, complaining of thirst and debility, had been under treatment since February; he then weighed twelve stone twelve pounds, and was passing eight pints and a half of urine, of specific gravity 1008 (average). He had noticed loss of flesh for eighteen months, having lost two stone weight by Christmas last, at which time thirst became a prominent symptom. No determining cause was apparent; his previous health had been good. No lung-change was perceptible. He had not been able to discover any change in symptoms to be dependent on diet, but found that beer made him worse; he takes sherry and water. He has been continuously treated with extract of valerian only, in increasing doses of four, eight, twelve, and fifteen grains three times a day, and is now taking forty-five grains daily. At present the amount of urine is five pints daily, of specific gravity 1012; no albumen, no sugar. He weighs thirteen stone, and is improved in his general health.

Favus.—This lad had been an in-patient for a year or more, and was shown to the Clinical Society two years ago (see James Bryan (*Transactions*). At that time he had the disease in a characteristic form, with well-developed "favus-cups," the marshy smell, etc. The case has improved, but has not been cured, though many plans of treatment have been carefully carried out with frequent epilation. He is a strumous lad, small for his age, with pale complexion, long eyelashes, large coarse teeth; arms, back, and chest hairy, a sign of degenerative type. Lately the glands of the neck have enlarged, and signs of pulmonary phthisis have developed. The head is now very impetiginous; it was ordered to be kept clean with oily poultices and thorough washing. As to diet, milk, bacon, and fatty food are recommended; but, unfortunately, this is unpalatable to the boy. He was ordered cod-liver oil and tonic mixture.

Double Facial Palsy.—A man, aged 33, was completely deaf with both ears; no otorrhœa. There was double facial palsy, complete on the left side, less so on the right. There were no signs of syphilis, but there was necrosis of the lower jaw, resulting from an injury four years ago. The deafness and facial palsy came on last October. The case was transferred to the aural surgeon.

Emphysema and Facial Palsy.—A man, aged 50, presented the usual signs of emphysema and chronic bronchial catarrh. The condition of his face was remarked upon, the puffy cushiony state of his cheeks, with dilated venules and deeply marked labio-nasal furrows. There was slight facial palsy of the right side, not complained of by the patient, and not very apparent till he was made to grin and show his teeth, and then close his eyes; the thickened indurated condition of the face concealed the partial palsy. On inquiry, a scar was found behind the ear, where a tumour had been removed when he was ten years old; doubtless the facial nerve had been injured then.

Varicosities of the Face were pointed out as being common in cabmen and others much exposed to the weather, also in those addicted to alcohol, or the subject of emphysema, or cirrhosis of liver or kidneys, and as especially worthy of note when occurring at an early age.

Bronchiectasis and Fetid Bronchitis.—A woman, aged 24, complained of dragging pain in the left side of the abdomen and some cough. It was noticed that the ungual phalanges were markedly bulbous; this suggested some chronic obstruction to the circulation within the thorax, such as fibroid changes in the lungs, emphysema, mixture of arterial and venous streams in the heart, etc. A similar condition of "bulbous nose" is not uncommonly seen in such cases. Nothing was found wrong in the abdomen, except a loaded colon; constipation is often of a week's continuance. The left side of the chest was found contracted, with signs of fibroid induration, contraction of the lung, and bronchiectasis. She had been ill for eighteen months with fetid bronchitis and slight hæmoptysis. Five years ago she was laid up with acute chest trouble, and the patient has noticed her fingers enlarging since then. Probably there is great thickening of the pleura, with adhesions, the lung being contracted. The heart is not displaced. She was ordered ten drachms of confection of senna in the morning; cod-liver oil, quinine mixture with ten minims of glycerine of carbolic acid, and to have the chest painted with iodine liniment.

Bromine Acne was produced in a girl, aged 18, by using half a drachm of bromide of ammonium twice a day to check her epileptic fits. The following lotion almost completely removed them during the continuance of the bromide mixture: ℞. Sulphuris precipit. ʒiij; spiritûs camph. ʒj; aquæ calcis ad ℥iij. Fiat lotio.

Insomnia, depending upon excessive mental activity, as the worry of business or other anxiety, may generally be best treated by bromide of potassium, taken early in the evening, and followed by a light supper. This allows the full absorption of the drug before the hour of rest, and renders its action more certain. Dr. Duckworth has tried lupuline extensively, but has not found its action as a soporific satisfactory. —*British Medical Journal*, May 19, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

American Medical Association. — The twenty-eighth annual meeting of this Association was held in Chicago, on June 5th, 6th, 7th, and 8th. About 650 delegates were present.

First Day.—The Association was called to order by Dr. J. Marion Sims, who introduced the President elect, Dr. Henry I. Bowditch, of Boston. Dr. N. S. Davis, on behalf of the medical profession of Chicago, delivered an address of welcome, and Dr. Bowditch then read the annual address, which had for its title, The Past, the Present, and the Future of the Association.

Dr. Bowditch recalled the enthusiasm that prevailed at the earlier meetings, at which the *élite* of the profession from all quarters of the Union attended and read papers or took part in the debates, and contrasted it with the present. He thinks we must admit that the meetings, with perhaps a few exceptions, rarely are carried out with the entire co-operation of the *whole* profession, as they were in the earlier years of its existence; and he is sure that the meetings have lost reputation in the Eastern and Middle States, and he infers that a similar feeling exists elsewhere, because he notices the absence of some of the prominent Western and Southern men. This result he ascribes to the action of various causes; he thinks too much was expected of the Association, that the meetings were victimized by individuals who were smitten with the *cacoethes scribendi aut loquendi*, that the *Transactions* have been made bulky by the publication of many worthless papers, and that the representation in the Association is too large.

As regards the labours of the publication committee, Dr. Bowditch suggests, that, as in the Smithsonian publications, nothing shall be published but that which, after having been read, shall have been approved by a committee of experts, whose names shall be unknown. To advance the scientific character of the meetings, Dr. Bowditch advocated the appointment of a standing committee of five to procure scientific papers for each annual meeting, abstracts of which papers should be published some months in advance, so that members could come to the meetings prepared for abler discussion of the topics involved.

On motion of Dr. Brodie, of Mich., the thanks of the Association were tendered to the President for his interesting address.

Dr. Brodie also moved that the recommendations contained in the address be referred to a special committee of seven; carried. Vice-President Pittman, of North Carolina, appointed the following committee: Drs. William Brodie, of Michigan; S. D. Gross, of Philadelphia; Eugene Grissom, of North Carolina; J. R. Smith, U. S. A.; J. K. Bartlett, of Wisconsin; J. P. White, of New York; J. M. Toner, of the District of Columbia.

Second Day.—Dr. Brodie, of Michigan, chairman of the committee appointed to consider the propositions contained in the address of the President, made the following report:—

Your special committee, to whom was referred the recommendations in the President's annual address, respectfully report that they have had the same under consideration, and recommend as follows:—

1. The Smithsonian plan: It is believed that if the officers of the Sections should perform their duties promptly under the existing regulations there would be no necessity for further examination.

2 In the matter of a standing committee to procure papers on scientific subjects, it is or should be part of the duty of the chairman of the Sections to obtain suitable matter for their respective Sections, at as early a time after their appointment as possible; and it is believed this would effect what the President proposes.

3. On permanent members and representation, we do not think it best at the present time to make or suggest any change in the present plan of organization.

4. On the subject of the union of this Association with the Canada Medical Association, we consider the same impracticable, and are of opinion that the present system of intercourse between the societies by delegates serves to meet the requirement.

5. On the question of the Pharmacopœia, we deem it inexpedient at the present time to take any action in the premises.

A motion to adopt this report was laid upon the table, upon the statement by the President that he wished to make some further statements regarding the subjects involved.

Dr. Squibb, of Brooklyn, read an essay on the "Revision of the U. S. Pharmacopœia." His views on the subject have been already laid before our readers.

Dr. P. G. Robinson, of Missouri, delivered the Address in Medicine.

Dr. James P. White, of Buffalo, delivered the Address in Obstetrics.

The Committee on Nominations was announced.

Third Day.—The Committee on Prize Essay reported that but one essay had been placed in its possession in time to permit of a reasonable examination, and that they do not consider it entitled to the prize. Another was received only a few days before the opening of the present session, and, as they had not been able to examine it, they recommend that the author be permitted to withdraw it and present it at the next meeting. The report was adopted.

The Judicial Council reported in regard to several cases before them of disputes as to representation, recommending in the case of the dispute between the Arkansas State Medical Society and the Arkansas State Medical Association, which was decided in favour of the former last year, that no further action be taken, and that the application for the admission of a delegate from the latter body be refused. They also reported favourably on the admission of delegates from the Branch County Medical Society of Michigan, and against the admission of a delegate from the Hendricks County Medical Society. In the matter of certain charges made by Dr. G. E. Frothingham against the Michigan State Medical Society and against Drs. Foster Pratt, of Kalamazoo, and G. K. Johnson, of Grand Rapids, the Committee reported that the charges had no bearing on the professional character of the defendants, and should therefore be dismissed. All the reports were accepted.

The Committee on Publication presented their report.

The Treasurer reported as follows:—

Under the positive instruction of the Association the prize essay has been published at a cost of some $6000. This unusual outlay, in addition to the annual volume of *Transactions*, leaves the treasury in an exhausted condition, as it has practically given to each member nine dollars in value for five dollars received. In this his last report, after twenty-two years of service, it remains for the Treasurer to thank the Association for its long-continued confidence, and to regret that in leaving the treasury solvent he cannot leave a more abundant surplus.

It was stated that the treasury now contains a balance of $172.72.

Dr. Ezra M. Hunt, of New Jersey, delivered the address in State Medicine and Public Hygiene.

Dr. Squibb concluded his remarks on the Pharmacopœia question by stating that the Association had three courses before it. The whole subject might be laid on the table, and this would be most acceptable to the speaker, who would thus be freed from all further responsibility in regard to a much-disputed question, the discussion of which had already developed much personal feeling. In the second place, they might prepare a plan and offer it to the profession, allowing it to stand upon its merits. And in the third place, they might appoint through the Nominating Committee a committee of three to prepare a report for presentation at the meeting next year. He would be glad to listen to discussion, and suggested that it be confined to a consideration of these three points. He moved, therefore, that the whole subject be laid upon the table.

This method of promoting discussions (a motion to lay on the table being not debatable) did not meet the views of the Association, and was withdrawn.

Dr. Brodie, of Michigan, offered the following resolution:—

Resolved, That a committee of five be appointed by the President, to whom shall be referred the paper of Dr. Squibb, and all the papers on the subject of the Pharmacopœia, with full authority to examine into the whole question as to the propriety of this Association being a factor in whole or in part in its publication, and report at the next annual meeting.

Dr. N. S. Davis, of Illinois, believed that if the Association entered as a factor with any other body in the preparation of a Pharmacopœia it would have to assume whatever of praise or odium attached to that work. While yielding to none in his respect for the Association, he held that they should keep free from incurring pecuniary obligations, from purchasing copyright interests, and contracting entangling alliances. He believed in allowing the convention to do its work, and to send such men to that convention as it could depend on. He favoured the indefinite postponement of the whole matter, and made a motion accordingly.

Dr. Brodie withdrew his resolution. The motion of Dr. Davis was put to a vote, and carried by a large majority. The announcement was greeted with applause.

Dr. S. D. Gross, of Pennsylvania, Chairman of the Committee on Nominations, offered a partial report, and asked a temporary change in the order for the purpose of receiving it. This was granted, and the Secretary read out the following recommendations:—

President.—T. G. Richardson, of Louisiana.

Vice-Presidents. — J. P. White, New York; Moses Gunn, Illinois; G W. Russell, Connecticut; A. Dunlap, Ohio.

Chairman of Section of Medicine, Materia Medica, and Physiology.—A. L. Loomis, New York. *Secretary*, J. H. Etheridge, Illinois.

Chairman of Section of Obstetrics and Diseases of Women and Children.—E. W. Jenks, Michigan. *Secretary*, H. O. Marcy, Massachusetts.

Chairman of Section of Surgery and Anatomy.—H. H. Smith, Pennsylvania. *Secretary*, E. T. Early, Arkansas.

Chairman of Section of Medical Jurisprudence, Chemistry, and Psychology.—W. Kempster, Wisconsin. *Secretary*, E. A. Hildreth, West Virginia.

Chairman of Section of State Medicine and Public Hygiene.—J. L. Cabell, Virginia. *Secretary*, E. J. Marsh, New Jersey.

Next place of meeting, Buffalo, N. Y. Time, first Tuesday in June, 1878.

The report was unanimously adopted.

Fourth Day.—Dr. Lilly, of New Jersey, presented a memorial relating to the revision of the U. S. Pharmacopœia, from the New Jersey State Medical Society.

Dr. T. M. Drysdale, of Pennsylvania, was appointed a delagate to foreign medical societies, and Drs. Clifton E. Wing, of Massachusetts, and Wm. Brodie, of Michigan, to the Canada Medical Association.

The Committee on Nominations presented the following additional report:—

Assistant-Secretary.—Dr. E. N. Brush, of New York.

Committee of Arrangement.—Drs. Thos. F. Rochester, J. F. Miner, E. R. Barnes, C. C. Wyckoff, M. B. Folwell, W. C. Phelps, and E. N. Brush.

Committee of Publication.—Drs. W. B. Atkinson, T. M. Drysdale, A. Fricke, S. D. Gross, C. Wister, R. J. Dunglison, of Pennsylvania, and William Lee, of D. C.

Treasurer.—Dr. R. J. Dunglison, of Penna.

Judicial Council.—Drs. J. K. Bartlett, of Wisconsin; F. Staples, of Minnesota; E. Grissom, of North Carolina; W. S. Robertson, S. Lilly, of New Jersey; W. M. McPheeters, of Missouri; and A. T. Woodward, of Vermont.

Committee on Prize Essays.—Drs. E. M. Moore, T. Lothrop, W. Miner, H. R. Hopkins, and E. W. Dean, of Buffalo.

The report was adopted.

Dr. J. W. Singleton, of Ky., offered the following resolutions, which were adopted:—

Resolved, That whereas it has come to our knowledge that a bill, known as the Morrison Bill, for the discontinuance of the tariff on quinine, is at this time before the Committee of Ways and Means in the Congress of the United States; and, whereas the welfare of a large portion of the people in the Western States and Territories is concerned in the issue of this bill, as well as any movement which will enable them to obtain quinine at a less cost than the enormous prices now paid by the consumer; and, whereas the opposition to this bill set forth by the manufacturers and trade does not represent the desire of those who are engaged in the relief of suffering and want, but ignores entirely the necessities of a large population, many of whom are engaged in cultivating the soil and opening up new resources of wealth to the government in malarial districts; and, whereas principles of justice and humanity alike demand free quinine and an open market for the competition of European manufacturers,

Resolved, That the American Medical Association approve of the passage of the "Morrison bill," for the repeal of the tariff on quinine, and respectfully insist that said bill shall become a law.

On motion of Dr. Henry H. Smith, of Penna., it was

Resolved, That the American Medical Association have heard with regret of the failing health of its former President, Dr. George B. Wood.

Resolved, That the Association respectfully tender him their sympathy in his illness, and desire to record their appreciation of his life-long efforts to advance the highest interests of the Medical Profession.

On motion of Dr. N. S. Davis, of Ill., Dr. Lewis A. Sayre, of New York, was appointed a delegate to the British Medical Association.

On motion of Dr. J. M. Toner, of D. C., it was

Resolved, That Dr. Francis Gurney Smith, who retired from the Chairmanship of the Committee of Publication last year, on account of ill health, after many years' service therein, is entitled to, and is hereby tendered, the sincere thanks of this Association, for the admirable and satisfactory manner in which he so long discharged the arduous and exacting duties of the office.

On motion of Dr. J. F. Hibberd, of Ind., it was

Resolved, That this Association, in view of the retirement from the office of Treasurer of the gentleman who, for twenty-two years, has discharged the responsible and laborious duties of that situation, desires in this manner to express its high appreciation of and full satisfaction with the promptness and completeness with which Caspar Wister has discharged the incumbent obligations of its financial agent for so many years, and hereby tender to him the sincerest thanks of the Association for such long and honourable service.

After discussion of the recommendations contained in the President's Address, it was moved by Dr. J. P. White, of New York, and carried, that these recommendations be referred to a select committee of five, of which Dr. N. S. Davis, of Ill., and Dr. Henry I. Bowditch, of Mass., shall be members, to recommend what legislation may be proper.

Dr. J. J. Woodward, U. S. A., moved that, including this meeting and hereafter, the practice of printing in the Transactions of this Association the so-called verbatim reports of the debates in the Sections be discontinued, and that the reports of the Sections be limited to the papers presented and recommended by the Sections for publication, and such minutes as may be actually read and adopted by each Section during the session of the Association. Adopted.

On motion of Dr. Brodie, of Mich., it was unanimously

Resolved, That the earnest thanks of this Association are hereby tendered to the Committee of Arrangements, for the excellent accommodations furnished at this session, and for the valuable order of business so carefully prepared for the meetings; and also to the citizens of Chicago, particularly Messrs. Pullman, Wirt-Dexter, Crain, Winston, Peabody, Bishop, Drs. R. N. Isham, E. O. F. Roler, and W. H. Ross, and their ladies, for their magnificent and hospitable entertainments; also to those railroads which have granted commutations to the delegates.

Dr. Squibb, of New York, asked permission to withdraw his paper on the Revision of the Pharmacopœia, as it had been read only in part, and he did not wish it to be published unless entire. On motion of Dr. Toner, of D. C., permission was granted.

Dr. T. G. Richardson, of La., President-elect, was introduced by Dr. Bowditch, and on assuming the chair, in some well-chosen and graceful remarks tendered his acknowledgments for the high honour conferred upon him by the Association.

Adjourned.

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Association of American Medical Colleges.—The Provisional Association of American Medical Colleges met in Chicago on June 1, and resolved itself into the American Medical College Association. Twenty four colleges were represented.

The following officers were elected: President, Dr. J. B. Biddle, of Jefferson Med. Coll., Phila.; Vice-President, Dr. N. S. Davis, of Chicago Med. Coll.; Secretary, Dr. Leartus Conner, of Detroit Med. Coll.

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American Ophthalmological Society—The annual meeting of this Society will be held July 26th and 27th, at the Cataract House, Niagara Falls.

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American Dermatological Association.—The first annual meeting of the American Dermatological Association will be held at Niagara Falls on the 4th of September.

The titles of all papers to be read should be forwarded to the secretary, Dr. L. Duncan Bulkley, not later than one month before the first day of the session.

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American Gynæcological Society.—The second annual meeting of this Society was held in Boston on May 30th, 31st, and June 1st, the president, Dr. Fordyce Barker, of New York, in the chair. The meeting was eminently successful; it was largely attended, and a number of interesting papers were read. The following officers were elected for the ensuing year: President, Dr. Ed. R. Peaslee, of New York; Secretary, Dr. Jas. R. Chadwick, of Boston; Treasurer, Dr. Paul F. Mundé, of New York. The next meeting will be held in Philadelphia in September, 1878.

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Connecticut Medical Society.—The eighty-sixth annual meeting of this Society was held at Hartford, May 24 and 25; Dr. A. W. Barrows, President, in the chair. The following officers were elected for the ensuing year: President, Dr. R. Hubbard, of Bridgeport. Vice-President, Dr. C. M. Carleton, of Norwich. Secretary, Dr. C. W. Chamberlain, of Hartford.

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Medical Society of New Jersey.—The one hundred and eleventh annual meeting of this venerable Society was held at Trenton, May 22 and 23. The President, Dr. J. W. Schenck, of Camden, presiding. The following officers were selected for the ensuing year: President, H. R. Baldwin, M.D. Vice-Presidents, Drs. John S. Cook, A. W. Rogers, and A. N. Dougherty. Secretary, Wm. Pierson, Jr. The next meeting will be held at Spring Lake.

Indiana State Medical Society.—The annual meeting of this Society was held at Indianapolis, May 15th. The following officers were elected for the ensuing year: President, Dr. L. D. Waterman, of Marion County; Vice-President, Dr. N. P. Howard, of Hancock County; Secretary, Dr. G. W. Wollen, of Marion County.

Illinois State Medical Society.—The twenty-seventh annual meeting of this Society was held at Chicago on May 15, 16, and 17, Dr. T. D. Fitch, of Chicago, President, in the chair. The following office-bearers were elected for the ensuing year: President, Dr. J. L. White, of Bloomington; Vice-Presidents, Drs. E. P. Cook, of Mendota, and B. M. Griffith, of Springfield. The next meeting will be held at Springfield.

Michigan State Medical Society.—The eleventh annual meeting of this Society was held at Battle Creek, May 9th, Vice-President Foster Pratt in the chair. The following officers were elected for the ensuing year: President, Dr. Foster Pratt; Vice-Presidents, Drs. John B. White, of Saginaw; J. A. McGraw, of Detroit; H. B. Barnes, of Ionia; J. H. Briggs, of Mattewan; Secretary, Dr. G. E. Ranney, of Lansing. The next meeting will be held at Lansing.

State Medical Society of Arkansas.—The annual meeting of this Society was held on May 1st. The following officers were elected for the ensuing year: President, Dr. A. N. Carrigan, of Hempstead Co.; Vice-Presidents, Dr. Pollard, of Washington, A. A. Horner, of Phillips, Drake McDowell, of Hot Springs, and J. A. Stinson, of Jackson; Secretary, Dr. R. J. Jennings, of Little Rock.

Medical Society of California. — The seventh annual meeting of this Society was held at San Francisco, on the 18th of April, the President, Dr. W. Fitch Cheney, in the chair. The following officers were elected for the ensuing year: President, Dr. Washington Ayer, of San Francisco; Vice-Presidents, Drs. L. C. Lane, of San Francisco, A. W. Saxe, of Santa Clara, J. M. Briceland, of Shasta, and Thomas Ross, of Tolo; Secretary, Dr. G. G. Tyrrell, of Sacramento. San Francisco was designated as the next place of meeting.

Medical Society of the State of North Carolina.—The twenty-fourth annual meeting of this Society was held at Salem, May 22d and 23d, Dr. Geo. A. Foote, President, in the chair. The following office-bearers were elected for the following year: President, Dr. R. L. Payne, of Lexington. Vice-Presidents, Drs. F. M. Rountree, of Snow Hill, R. Anderson, of Albemarle, S. P. Flowers, of Mount Olive, L. A. Stith, of Wilson. Secretary, Dr. L. J. Picot, of Murfreesboro'. The next meeting will be held at Greensboro' on the second Tuesday in May, 1878.

Medical Society of Georgia.—The annual meeting of this body was held at Macon on the 18th of April, Dr. L. D. Ford, presiding. The following officers were elected for the ensuing year: President, Wm. O. Daniel, M.D., of Twiggs; Vice-Presidents, Drs. D. W. Hammond, of Macon, and S. B. Hawkins, of Americus; Secretary, Dr. J. B. Baird, of Atlanta. The next meeting will be held at Atlanta on the third Wednesday in April.

Jefferson College Hospital.—This new structure, which is situated on Sansom Street, about sixty feet west of the college building, was opened for inspection on 29th of May. The building is bounded on three sides by streets and on the fourth by a private passage-way, and is 107 feet square. The hospital proper is five stories high, with a capacity for 125 beds, and is built in the shape of an L. The amphitheatre occupies the angle, and rises to the level of the third story, thus in no way obstructing the free access of air and light to the wards, which occupy the third and fourth floors, and have windows on both sides and at the end.

The amphitheatre is one-story high and fitted up with circular benches which are so arranged as to afford from all sides an unobstructed view of the lecturer, and has a seating capacity of 600. Immediately over the lecturer's entrance has been placed an excellent bust of the late Dr. George McClellan, the founder of the Jefferson College, presented by Dr. John H. Brinton.

On the first floor of the hospital building proper are the lecturers' private rooms, the general reception room for out-patients, rooms for special clinics, and the pharmacy.

On the second floor are a receiving ward, a ward for septic cases, eye ward, gynæcological ward, and a private operating room, with steward's offices, etc. On the third floor are the two male wards each 15 feet high, the surgical 70×40, and the medical 60×33.

The fourth floor is the counterpart of the third, and its wards are intended for females. On each of these floors are a special diet kitchen, dining-room for convalescents, vapour-bath-room lined with glass, etc. Each ward has two open fireplaces, water-closets, bath-rooms, etc. The fifth story contains handsomely furnished rooms with every convenience for private patients.

The basement contains the kitchen, which is connected with the wards by dumb-waiters, a steam disinfecting chamber, mortuary, etc. All soiled clothes are conveyed through a galvanized iron shute extending from the top of the house to the basement.

The walls are plastered with hard coating; the angles are rounded so as not to hold dust or dirt; and the floors are oiled and waxed.

The staircase is fire-proof, and is built around a well containing the steam elevator which runs from the basement to the top of the building, and is large enough to hold a bed. Electric bells and speaking-tubes connect all parts of the hospital.

The ventilation is threefold: 1st. By windows and doors; 2d by open fires; 3d by double sets of foul air flues arranged alternately near the ceiling and floor, one set communicating downwards with a ventilating stack 104 feet high where an upward current is insured by the heat of the steam boilers. The other set of flues extends upwards to the loft which is fitted up with a ridge, and upward air currents are promoted by steam pipes.

The heating is effected by steam, and fresh air is admitted through registers placed behind the steam coils.

The hospital is a handsome brick building with Ohio sandstone facings; the interior is complete in every particular, and the arrangements reflect credit upon the architect and building committee. We have always considered that for successful medical teaching it is essential to have a hospital in connection with the college, and we congratulate the Jefferson faculty upon the possession of this valuable addition to their educational resources.

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University of Pennsylvania.—At a meeting of the Board of Trustees of the University, held on the 5th of June, two of the vacant chairs in the Medical Department were filled as follows: Dr John Ashhurst, Jr., was elected Professor of Clinical Surgery, and Dr. Theodore G. Wormley, of Columbus, Ohio, Professor of Chemistry. The Professorship of Physiology was left vacant, and Prof. Tyson was appointed to deliver the course next winter. Prof. Tyson, we are informed, is not a candidate for the chair.

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Catalogue of the Alumni of the Medical Department of the University of Pennsylvania.—The Society of the Alumni have authorized the publication of a complete catalogue of the graduates of the Medical Department of the University. Copies may be obtained by inclosing a subscription of one dollar to the Secretary of the Society, Dr. Horace Y. Evans, N. E. cor. Green and 17th Sts., Philadelphia.

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Dialyzed Iron.—We have received from John Wyeth & Brother, the well-known pharmaceutists of this city, a sample of this new preparation, which is a neutral solution of peroxide of iron in the colloid form, obtained by separating by means of the process of dialysis the hydrochloric acid contained in a soluble oxychloride of iron. The dialyzed iron thus obtained is a concentrated solution of peroxide of iron, of a deep red colour and without styptic or other disagreeable taste, and it is stated that it neither blackens the teeth nor constipates the bowels. It will, no doubt, prove to be a very valuable preparation of iron.

FOREIGN INTELLIGENCE.

Periosteal Surgery in the United States.—In a short editorial with the above heading *The Lancet* (June 2, 1877), says: "We have been favoured with a look at the New Lower Jaw-bone alluded to in our report of the Congress of German surgeons at Berlin, and which we believe to be, if not a unique specimen at any rate the first specimen of the sort seen in Europe. We allude to it with the more pleasure, as the operator, Dr. James R. Wood, Emeritus Professor of Surgery in the Bellevue Hospital Medical College, is entitled to the great praise of having been one of the pioneers of periosteal surgery, which constitutes such a creditable and instructive chapter in the recent history of surgery. This particular operation was performed more than twenty years ago; and the merit of it consists not only in its having been then a new kind of operation, but in the details of the procedure, which had to be thought out for the first time, and which have since become recognized principles.

"It is a great feat of what we are disposed to call physiological surgery to take away a whole bone, and to do it so carefully and with such preservation of the periosteum as to have it entirely reproduced in perfect symmetry and perfectly *in situ.* The new jaw is smaller than the original one, but in other respects, in form and position, it is a wonderfully perfect reproduction. The patient was a girl eighteen years of age, working in a match factory; hence the phosphorous disease of the jaw, leading to necrosis and the necessity for removal. The operation was done by halves, one-half being left for weeks after the removal of the other, so as to steady the parts and determine the proper position of the new jaw, which would otherwise have been dragged down by muscles and caused great deformity. The patient perfectly recovered, and lived three years after. She then died of brain abscess, when the entire skull came into the possession of Dr. Wood. Both he and other operators have frequently repeated these operations with similar success. But the patients are mostly alive, and, as Langenbeck lately said at Berlin, there is not another such specimen in the whole of Europe as the one we now notice."

Extraction of Foreign Bodies from the Œsophagus in Children.—In allusion to a case in which there had been some difficulty in extracting a coin swallowed by a child, Dr. Thouvenin states that in such cases he adopts a very simple measure with great success. It consists in laying the child flat on his belly on a table, with his head, supported by an assistant, projecting beyond it. The finger is then introduced into the mouth in order to depress the tongue, and the coin slides out along the finger of the operator.—*Med. Times and Gaz.*, April 14, 1877, from *Bull. de Thérap.*, March 15.

Subcutaneous Injection of Salicylic Acid in Erysipelas.—Prof. Ferdinand Petersen, of Kiel, states, in a postscript to a communication of his in the *Deutsche Medicinische Wochenschrift* for January 13th, 1876, that he has on three occasions cut short the progress of erysipelas by injecting a gramme (about 15 minims) of a concentrated solution salicylic acid under the healthy skin surrounding the affected part. He has made several such injections at the same time in each of the three cases. Whether the happy result was due to the means employed, he will not dogmatically decide. It might be worth trying in other cases of erysipelas.—*Lond. Med. Record*, May 15, 1877.

Oxide of Zinc in Obstinate Diarrhœa.—Dr. Bonamy, of Nantes, relates (*Bull. de Thérap.*, March 30) some cases confirmatory of the great and speedy utility of oxide of zinc in obstinate diarrhœa that has resisted various other remedies. He employs the formula recommended by Prof. Gubler, who first used the remedy for this purpose, viz., three grammes and a half (fifty-three grains) of the oxide, combined with half a gramme (eight grains) of bicarbonate of soda, and divided into three or four doses—one to be taken every three hours. The addition of the soda prevents the production of vomiting by the zinc.—*Med. Times and Gaz.*, May 5, 1877.

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Death while under Ether at the London Hospital.—An old man, sixty-nine years of age, was admitted into the London Hospital on May 12, suffering with obstruction of the bowels. He appeared old, even for his age. He was in considerable pain, which was referred chiefly to the right iliac region, and there was some tenderness also in the same place, as well as over the rest of the abdomen, which was distended and tense. It appeared from the history that the symptoms dated from two days previously; he was the subject of hernia, which came down from time to time, although he wore a truss. Two days before, his hernia being down, he reduced it, the reduction causing pain. He had been sick previous to the reduction, and the vomiting and pain prevailed afterwards. The surgeon to the case diagnosed a reduction *en masse*, both from the history and also the appearance of a depression in the integument over the external ring; and it was thought that some portion of an old sac, which was adherent to this integument, had been reduced, and was dragging upon the integument, and so giving rise to the depression or dimpling of the soft parts. With a view to get the hernia down, and to obviate the struggling which the pain of this process gave rise to, ether was administered. Clover's inhaler was used. For about thirty seconds he inspired only his expired air; he then had, for about a minute, one-quarter to a half ether. There was some struggling at the commencement, and he did not breathe in the ether well. The mouthpiece was therefore frequently removed from his face. The amount of ether was then diminished, and as his lips looked blue it was entirely stopped; his breathing improved a little, but was not quite satisfactory. His pulse gradually became weaker, and finally stopped; respiration, however, continuing for thirty seconds or more. Sylvester's method of artificial respiration and galvanism were resorted to without success. The post-mortem examination showed that a large coil of small intestine had got caught in a figure-of-eight-shaped loop of mesentery adherent by both ends to peritoneum under the above-mentioned pouch. The intestine was very much inflamed, and of a deep purple colour. Left ventricle uncontracted and flaccid. Lungs: Extreme emphysema, and containing little blood. Slight bronchitis. It would seem as though the man died more of shock than of ether. The jury also held this view, and returned, "Death from natural causes."—*Med. Times and Gaz.*, May 19, 1877.

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Professor Lister.—The council of King's College, London, in order to have the benefit of Mr. Lister's teaching, have created a second chair of clinical surgery, which has been offered to him, and he has accepted. As Mr. Lister's antiseptic surgical practice requires that the patients so treated shall be kept separate from those who are not, the authorities of the hospital have placed two wards—one for female and one for male patients—at Mr. Lister's disposal.

It is reported that Mr. P. Heron Watson is likely to become a candidate for the chair of Clinical Surgery in the University of Edinburgh, vacated by Mr. Lister.

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The University of London and Medical Women.—At a very large meeting of convocation of the University of London, held in May last, it was resolved "That this house is of opinion that it is undesirable for this University to admit women to degrees in medicine before it shall have considered the advisability of admitting women to degrees in all faculties." The resolution was supported by Mr. Savory, Dr. Barnes, Dr. Quain, Sir William Jenner, Dr. Wilks, Dr. Wilson Fox, Dr. Poore, and others, and no one possessing a medical degree appears to have opposed it.

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BRISTOWE'S PRACTICE—Now Ready.

A TREATISE ON THE THEORY AND PRACTICE OF MEDICINE.

By JOHN SYER BRISTOWE, M.D., F.R.C.P.,
Physician and Joint Lecturer on Medicine, St. Thomas's Hospital.

EDITED, WITH ADDITIONS,
By JAMES H. HUTCHINSON, M.D.,
Physician to the Pennsylvania Hospital.

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Any one who wants a good, clear, condensed work upon Practice, quite up with the most recent views in pathology, will find this a most valuable work. The additions made by Dr. Hutchinson are appropriate and useful, and so well done that we wish there were more of them. —*Am. Practitioner*, Feb. 1877.

This portly volume is a marvel of condensation. In a style at once clear, interesting, and concise, Dr. Bristowe passes in review every conceivable subject connected with the practice of medicine. Those practitioners who purchase few books will find this a most opportune publication, because so many topics not usually embraced in a work on practice are adequately handled. The book is a thoroughly good one, and its usefulness to American readers has been increased by the judicious notes of the Editor.—*Cincinnati Clinic*, Jan. 7, 1877.

The is undoubtedly the best of the single volume text-books on practice of medicine published or republished in this country for the past eight or ten years. Its shortcomings are few.—*Va. Med. Monthly*, Jan 1877.

While he has done what he really intended to do, viz., presented every subject with all possible conciseness and brevity, there is nothing to warrant the conclusion that such a result is due to any want of that thorough preparation and knowledge requisite in a work of greater amplitude and pretension. Indeed, the experienced and candid reader will testify that there are no real evidences of the fact that this work is adapted only to the wants of junior practitioners and students; on the contrary, while the style is concise, it is polished, and conveys, as a rule, what would be demanded by the most experienced practitioners; while the number and variety of subjects discussed is really astonishing. It is a most excellent volume, and will be fully prized by all who possess a copy of it. The American editor has really improved the volume by his additions to it, and deserves warm commendation for his faithful and efficient labors. We have no general works on the practice of medicine that, in many respects, are so fully up to the results of modern researches.—*Journ. of Mental and Nervous Diseases*, Jan. 1877.

The above is an entirely new work on the practice of medicine. From the widely known and well-earned reputation of the author, this work is entitled to the highest consideration. It is eminently practical, and contains the most recent views on the pathology and treatment of diseased conditions. We cannot commend it too highly. —*Canada Lancet*, Jan. 1, 1877.

Upon reading it our first emotion was that of surprise—surprise mingled with pleasure, to perceive that, notwithstanding the same work had been done by so many, it could yet be done so much better. In 1056 pages the author has compressed the most complete treatise upon the theory and practice of medicine we have ever seen. Almost every disease known to the profession, including many not found in similar works, is treated of. As a handbook for students, therefore, we do not think it has an equal in the English language; while older members of the profession may consult it with equal pleasure and profit. The style is remarkably clear, plain, and familiar, and is perfectly comprehensible to the least cultivated; while the most highly cultured can hardly fail to be pleased at the purity of its English.—*Physician and Surgeon*, Baltimore, Nov. 1876.

It is impossible to look over its pages without being impressed with the amount of information which they have been made to contain, with no appearance of conciseness at the expense of completeness. A superficial survey even shows that, as a text-book, it is far in advance of those published only a few years ago; and a more careful examination of some of its sections—such, for example, as the one devoted to diseases of the nervous system—demonstrates that in provinces which have accomplished the greatest advances of late years, the author has kept his work quite abreast with the labors of the most reliable clinical observers. Features quite unusual in a purely medical treatise are included in the shape of excellent chapters on diseases of the skin, the affections of the genito-urinary organs in females, which can but result in lessening the tendency on the part of the general practitioner to neglect the important classes of complaints with the feeling that, like derangements of the chief organs of the special senses, they can better be managed by specialists.—*New Remedies*, Nov. 1876.

We recommend highly this book, and feel justified in doing so by the thought that, of its class it is the best we have yet seen. The judicious remarks of the American editor add very much to the value of the work. His jealous guard over American medicine is most praiseworthy: in fact, our only complaint is that so little of his own well-known style appears.—*Obstet. Journ. of Great Britain and Ireland*, Nov. 1876.

The work under consideration is, in many respects, a most admirable text-book. There is no pretence to encyclopædic completeness, but what the student wants, a short, compendious remembrancer, he will find in Bristowe's Practice. We regard the work as especially valuable to the student who wishes to classify, systematize, and remember the points of value made by his teachers, and to the busy practitioner who would review his knowledge of affections, and look for suggestions in the emergencies which continually arise in his daily life. The editor has done his work with conscientious care, and the American reader will find that the additions to medical science made by his countrymen have not been overlooked. Altogether, it is an excellent work, and will doubtless have a large sale.—*St. Louis Med. Record*, March, 1877.

The style is clear, the matter and method good. Whoever buys this book gets as complete a representation of modern medicine as has been, and probably can be put inside of one thousand pages of similar size and type.—*Phila. Med. Times*, Dec. 9, 1876.

HENRY C. LEA, Philadelphia.

MAR 1 1934

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CLINICS.

CLINICAL LECTURES.

A Clinical Lecture on Ovariotomy. Delivered in University College Hospital, London. By CHRISTOPHER HEATH, F.R.C.S., Holme Professor of Clinical Surgery, etc.

Gentlemen: You have recently had under your notice a case of multilocular ovarian cyst, and have had the opportunity of seeing me remove it by the operation of ovariotomy, with, I am happy to say, complete success; and I propose now to make a few clinical remarks upon the subject. The patient was a married woman aged 29, and the mother of four children. In 1873, after a confinement, she noticed that her abdomen remained large. She was confined again in July, 1874, the enlargement still persisting, and she wore an abdominal belt for nine months. In the early part of 1876, she noticed a hard lump in the abdomen, and applied for advice at a special hospital, when she was told that she had a fibrous tumour of the uterus, and attended for some months without benefit. She was recommended to me by a medical friend, and was admitted here on December 2, 1876, when the following was her condition, as reported by Mr. Smyth, the clinical clerk:—

The abdomen is greatly distended and of conical shape, the apex being midway between the umbilicus and pubes. There

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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is dulness over the front and sides of the belly, reaching three inches from the umbilicus on the right side, and almost to the flank on the left side, with tympanitic percussion above and to the sides of the dull area. The surface of the tumour, as a whole, is rounded, several sulci marking off distinct rounded portions; these are very tense and fluctuating, but there is no fluctuation from side to side of the whole tumour. Just to the right of the umbilicus, a flat and very hard lump is felt, about the size of an almond in its shell. The abdominal wall is marked with purple lines from stretching; it is thin and freely movable over the tumour. *Per vaginam*, the uterus was found to be normal in size, but pushed over the left side; to the right and in front of it, rounded masses were to be felt through the vaginal wall.

Now, I beg you will understand that the diagnosis of abdominal tumours, presumably ovarian, is by no means easy, and that the most experienced ovariotomists are liable to mistakes. Thus, tumours of the uterus have been confounded with ovarian tumours, and, *vice versâ*, cysts of the kidney and liver and enlarged spleens have all been taken for ovarian tumours; and, in fact, in many cases the late Mr. Baker Brown's *dictum* is undoubtedly true, that one cannot be certain about the nature of a given tumour until one's hand is actually upon it. Still, this was a remarkably easy case for diagnosis; the thin abdominal wall allowed the multiple cysts to be very distinctly felt, and the only unsolved question was whether the dulness in the left flank was due to some solid matter, or, as it proved, to tightly packed cysts with viscid contents. Under these circumstances, a preliminary tapping could have been of no service, as it sometimes is in cases complicated with considerable ascites by which the tumour is obscured, or cases of one very large cyst, possibly in the broad ligament, where a single tapping will often cure the case altogether.

I, therefore, recommended the patient to undergo the operation of ovariotomy, putting the risks fairly before her and her husband; and, upon her assenting, had her transferred, with Dr. Graily Hewitt's kind consent, to the house close by, which is devoted to the treatment of such cases under his care. My reason for doing this was that undoubtedly cases of ovariotomy do not do well in the general wards of a hospital, and that the only single ward at my disposal is at the top of the general staircase, and liable, therefore, to have noxious matters carried into it from below. I do not believe that the patient would have sustained any harm whatever if I had operated in this theatre, provided she could have been placed in an isolated bed afterwards; but, this being practically impossible in our present building, you had to follow the patient over the way to witness the operation. Now, the operation was done on a Thursday; and, on the previous day, I had made my visit here as usual, and the only restriction I put upon those who attended the operation was that they should not be in actual attendance upon cases of contagious disease. I learn from a paragraph in an American journal, that an eminent ovariotomist requires all who witness his public operations to sign a paper certifying that they have not seen a dead body or an infectious living case for seven days; but such a sweeping precaution, even if it can really be enforced, seems to me uncalled for, when the operator must, in the ordinary course of practice, be daily placing his fingers in contact with discharges from the uterus quite as offensive, and probably as dangerous, as anything met with even in a post-mortem examination. I do not think any one would be justified in making a post-mortem examination or going to an infectious case just before an ovariotomy; but I have great faith in a night's rest and a morning bath for removing all taint from the living body. Were it otherwise, indeed, I do not see how any one could practise his profession with safety, and the effect of such a regulation as that given above would be to confine ovariotomy to a very select circle of operators.

The operation was performed on December 6, the patient being under the influence of ether. I made an incision exactly in the middle line, three inches and a half long, beginning about midway between the umbilicus and pubes, and carrying it down towards the pubes. Having opened the peritoneum, I divided it to the same extent on a director, and the bluish cystic tumour at once came into view, there being no ascitic fluid. I then passed my hand in to make sure that there were no adhesions, and afterwards tapped the presenting cyst with a large trocar. Through this cyst, I tapped other cysts, but was unable to reach the large cysts in the left flank; and, therefore, having drawn the empty cysts forward, I tapped at a fresh spot. Having emptied two or three cysts through this opening, I was then able to draw the entire tumour out; Dr. Williams, who assisted me, carefully guarding against any prolapse of the intestines. The fluid of these cysts was thin and ran readily through the canula; but not unfrequently one meets with such dense cyst-contents that it is necessary to scoop them out with the fingers, the aperture in the cyst being enlarged with scissors so as to admit the hand, and the greatest care being exercised to prevent any escape of the contents into the peritoneum. The only adhesions were two of the omentum to the tumour, and these I tore through, afterwards putting fine silk sutures upon a couple of bleeding vessels.

Next came the important question of the treatment of the pedicle. Having tried all the modern plans, I gave the preference to that of "tying and dropping;" *i. e.*, I tied the pedicle with silk and cut the ligatures short, so that I might close the wound completely. In doing this, it is important that there should be no risk of the ligatures slipping, and the best way is to use a double ligature, passing it through the pedicle with a probe, and then tying the two halves separately; and then, as an extra precaution, one of the ligatures is made to encircle the entire pedicle again on the uterine side of the other ligatures. I then divided the pedicle half an inch beyond the ligatures, and removed the tumour, which weighed three pounds and three-quarters after the removal of five pints of fluid by the tappings. The tumour involved the left ovary; and I proceeded to examine the opposite one, and, finding cystic disease commencing there, I removed it with the same precautions. The edges of the incision were brought together with five silk sutures, which were passed deeply through the entire thickness of the abdominal wall, including the peritoneum. Mr. Spencer Wells settled the question of including the peritoneum by experiments on animals (the specimens from which are in the College of Surgeons' Museum), and showed that, if the edges of the peritoneum were brought together, they united rapidly by lymph, and thus effectually closed the peritoneal cavity again and prevented the access of inflammatory products. The same rule would hold good in cases of accidental wound of the peritoneum. No superficial sutures were used, but the abdomen was padded with cotton-wool and carefully strapped with plaster, so as to give support to the abdominal wall and contents, and thus to obviate vomiting to a great extent.

I need not trouble you with the details of the after-treatment, which consisted simply in careful nursing, a dose or two of morphia to relieve pain, a simple injection on the fourth day, and a dose of castor oil on the fifth day. The sutures (one of which set up a little suppuration) were removed on the seventh day after the operation; and the patient went home on December 23, seventeen days after the operation, in order to spend Christmas with her family.

Although ovariotomy was first performed in 1809 by McDowell, of Kentucky, who was a pupil of John Bell, the operation in modern times has been entirely of British cultivation. Mr. Lizars, of Edinburgh, was the first to attempt ovariotomy in this country, and by the long incision, *i. e.*, from the umbilicus to the pubes; his example was followed by a few other surgeons, and from time to time a success was recorded. The short incision, with withdrawal of the contents of the cyst, was adopted in 1836 by Mr. Jeaffreson, of Framlingham, but the pedicle and ligatures were still allowed to hang out of the wound, and to set up suppuration in the peritoneal cavity. The late Mr. Duffin, in 1850, first called attention to this danger, and proposed to keep the strangulated pedicle outside the peritoneum; and this method was improved upon in 1858 by Mr. Jonathan Hutchinson, who devised the clamp now in common use in some form. Mr. Spencer Wells, who has had the largest experience of any ovariotomist, had his first case in 1858; and since that time the operation has been performed by numerous surgeons, both in this and other countries, and is now a thoroughly established proceeding. My own experience has been comparatively small; the case you have seen being only my fifteenth; but the mortality has been small also, viz., three deaths, or one in five cases—this being, I believe, about the rate in Mr. Wells's much larger number of cases. One of my deaths was accidental, *i. e.*, it resulted from slipping of the clamp some hours after the operation, when internal hemorrhage occurred before the pedicle could be secured. On the other hand, I have never had occasion to abandon an operation, though one or two cases have been rather desperate ones, one case having been already attempted by another operator, who gave up and closed the wound successfully; and others having been already declined on account of adhesions. In the first of these, the parts were so matted together that I unawares divided a coil of small intestine; but, by making an artificial anus, the patient recovered, and is now in perfect health, with only a small fecal fistula, which gives her no inconvenience. (The case is recorded in the Clinical Society's *Transactions*, vol. v.)

The method of treating the pedicle I adopted in this case, viz., "tying and dropping," was brought into practice by the late Dr. Tyler Smith, who had a series of most successful cases, and it appears to me to possess two great advantages: 1. That it is applicable to all pedicles, whether long or short; and, 2. That it admits of immediate closure of the wound in its whole length. My personal experience of the clamp is limited to the case already mentioned, in which a fatal result ensued from the slipping of the pedicle through the clamp, for I never again employed it; but I have seen it used frequently, and it does very well when the pedicle is long. But in many cases the pedicle is so short that very considerable traction upon the uterus is exercised in order to get the clamp outside the abdominal wall, thereby causing pain. Another objection is that the stump sometimes gives trouble if it become adherent to the cicatrix, a regular menstrual discharge taking place occasionally every month. Still, it is right that you should know that Mr. Wells has employed the clamp in the greater number of his cases. Mr. Baker Brown introduced the practice of dividing the pedicle with the actual cautery, and devised a cautery-clamp, which I show you here. I have employed it in several of my cases with good effect, but I do not think it so safe as the ligature; for, however careful you may be to cut the pedicle slowly with an iron not too hot, so as to sear the cut edges thoroughly, there is always the risk of some small vessel bleeding and requiring a ligature, and sometimes the burnt edges become separated and the bleeding is free. It is exactly the difference between applying torsion to a large artery and putting on a ligature; with the last, one feels perfectly safe, whilst with the former something *may* go wrong.

You may ask what becomes of the ligatures left in the abdomen. They become rapidly coated with lymph and buried completely, so that it is impossible to find them a few months afterwards. Possibly silk, being an animal product, may undergo partial absorption, as has been suggested; but twine ligatures do practically just as well, and are as completely hidden.—*British Med. Journ.*, June 16, 1877.

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Case of Suspected "Discharging Lesions" of the Hinder Part of the Uppermost Right Frontal Convolution; Illustration of Ferrier's Researches.—During his charge of the clinical wards at the London Hospital, Dr. Hughlings Jackson showed several patients who were subject to convulsions beginning locally, in some part of one side of the body. With reference to them he urged the great importance of the researches of Hitzig and Ferrier, and drew attention to the statement of Charcot that a French physician, Bravais, had, in 1827, described the clinical varieties of epilepsy or of epileptiform seizures under remark. One case was that of a man who had convulsions usually affecting only the left arm; the convulsion was always preceded by an epigastric sensation, probably the same as, or one allied to the strange epigastric feeling so often mentioned by patients the subjects of what is usually called "genuine" epilepsy as a warning of their seizures. Besides the limitation of nearly all the seizures to the arm, there was another very noteworthy peculiarity; according to the patient, the spasm always passed *down* the arm. This is a credible thing; Dr. Hughlings Jackson has witnessed such a mode of spreading of spasm in a woman who had very numerous convulsions limited to the right arm. In that woman's case a gliomatous tumour was found affecting the hindermost part of the uppermost frontal convolution, and slightly involving the upper end of the ascending frontal of the side opposite the arm convulsed. The position of disease in this woman's case was correctly predicted, from there having been discovered disease of the part named in another case previously under Dr. Hughlings Jackson's care, in which case also the convulsion had been limited to the arm. This was before Ferrier began his important researches; but it is to be observed that this "localization by disease" closely agrees with one of his conclusions. Thus, at p. 306 of his recently published "Functions of the Brain," Ferrier writes, when describing a plate of the brain wherein the motor centres are indicated: "(5) Situated at the posterior extremity of the superior frontal convolution, at its junction with the ascending frontal, is the centre for the extension forwards of the arm and hand, as in putting forth the hand to touch something in front."

Considering this woman's case, another essentially similar case also alluded to above, and some facts of a case less conclusive, and more especially the very definite results of Ferrier's experiments, Dr. Hughlings Jackson ventures, in the case of the man recently in the clinical wards, on the diagnosis of a "discharging lesion" of the hindermost part of the right uppermost frontal convolution. Dr. Ferrier saw this patient with Dr. Hughlings Jackson, and agreed with him in the above diagnosis.

This patient has a very curious feeling in his paroxysms, which Dr. Hughlings Jackson has never before heard of in a case of convulsion of any kind. The patient said that during the fit his hand seemed to get gradually up to his shoulder, and at length seemed to be buried in his chest. This is worthy of mention, on account of the somewhat similar feeling of some of those who have undergone amputation of a limb; the "spectral" hand or foot, in course of months or years, gets gradually nearer and nearer to the shoulder or hip.

What kind of disease there may be which is the cause of the "discharging lesion," Dr. Hughlings Jackson does not venture to say; there is no evidence of tumour, unless the limitation of the spasm is some empirical evidence of it.

Remarks on discharging lesions, by Dr. HUGHLINGS JACKSON.—A "discharging lesion" is an abnormal physiological state; there is local instability of gray matter. The difficulty here, as in most cases of epilepsy and epileptiform seizures, is to ascertain the pathology—that is to say, the nature of the local abnormal nutritive process by which the local instability results.

Dr. Hughlings Jackson continually insists on the necessity of making a distinction between the abnormal physiological condition (the morbid alteration of the function of nerve-tissue) and the abnormal nutritive process (pathology) by which the abnormal physiological condition is brought about. The term "disease" is frequently used for both or either; no analysis being attempted. The distinction is most easily shown in cases of paralysis. Paralysis points only to the abnormal physiological condition of loss of function of nerve-tissue, and often to actual destruction of nerve-tissue; it tells us nothing whatever as to the nature of the pathological process by which that loss of function results. Similarly, convulsion (as also choreal movements, tetanus, etc.) points only to the abnormal physiological condition of over-function (not better function), or, in other words, to a "discharging lesion," constituted by unstable cells, but convulsion tells us nothing as to the pathological process by which that condition of over-function results. It will be observed that Dr. Hughlings Jackson uses the term "functional" simply to describe what is commonly agreed upon to be the function of nerve-tissue, and not for slightness of charge, nor for cases in which recovery quickly follows; there are, in this sense of the word, only two kinds of functional changes—those of loss of function and those of over-function. Speaking now only of over-function from morbidly increased instability of nerve-cells, we must go so far as to say that there is increased nutrition; for increased expenditure of energy of necessity implies increased "absorption" of energy—that is, increase of the nutritive process. The difficult question is: "How is this local increase of nutrition determined?" Even when we discover a tumour we have this problem to consider. A tumour is found, let us say, in the uppermost frontal convolution, close upon the ascending frontal; there were frequent convulsions of the opposite arm during life. Now the tumour cannot discharge; the discharge is of gray matter, and, as Dr. Hughlings Jackson supposes, of gray matter round about the tumour. But whether this be so, or whether the discharge be, as many would believe, of the medulla oblongata, the difficult question is: By what process did the tumour lead to instability of cells permitting occasional excessive discharge, be those unstable cells where they may?

Thanks to Hitzig and Ferrier's researches, the locality of "discharging lesions" is, Dr. Hughlings Jackson thinks, a matter on which physicians have been wonderfully and unexpectedly assisted. But a great void remains to be filled with regard to the pathological process by which discharging lesions result. But even here it is probable that Ferrier's researches will help us. For particular pathological processes affect, so to speak, particular seats. And in this regard the researches of Duret on the distribution of cerebral arteries ought to be very carefully considered. Dr. Hughlings Jackson's speculation is, that in most cases where there is found no tumour as a cause of convulsion, the "discharging lesion" is the result of embolism or thrombosis of arteries.—*Lancet*, June 16, 1877.

HOSPITAL NOTES AND GLEANINGS.

Hospital Notes. Guy's Hospital (Dr. Moxon).

Spinal Sclerosis.—A tradesman's clerk, aged 21, with red hair and fairly intelligent appearance, complains of unevenness of gait in walking and difficulty in speaking. He has suffered from these paralytic symptoms during the last seven years. His speech is defective, he is slow in getting out his words and in forming the sounds, but he speaks without any want of intelligence. The movements of the tongue in the mouth present no abnormalities to the eye, and the power of the labio-glossal muscles, as indicated by the power to blow out a candle at a distance, presents no defect. In walking, the body swaggers; there is ataxia, but not complete "locomotor ataxia." In standing, the feet are widely separated, he cannot stand with his eyes shut, and says to attempt to do so makes him giddy. There is no muscular tremor, such as is seen in lateral spinal sclerosis. He has no difficulty in urinating. The eyes present no abnormalities in movement or ophthalmoscopic appearance. There are no dysæsthetic sensations of "girthing," etc., and no numbness. An elder brother is said to be similarly affected in a greater degree; another brother, aged 17, was seen; he usually stands with feet separated, and is unable to do so with his eyes shut; his gait is defective, but not so much so as the patient's. A sister is also said to be ataxic. There is no blood-relationship between the parents. There is here an absence of all cerebral symptoms; probably there is sclerosis confined to the spinal cord, and most probably in the posterior column. The prognosis of ordinary spinal sclerosis is, however, hardly warranted here. The treatment consists of tonics and cod-liver oil.

Cervical Chorea, or Muscular Tic.—An elderly man presented a curious lateral oscillation of the head and neck, but no general paralysis agitans; he also complained of want of sleep. This has been his condition for three years. Dr. Radcliffe's method of hypodermic injection of arsenic was tried, five minims of liquor arsenicalis being injected in the neck. This produced no good effect; and troublesome local boils and suppurating sores resulted, which have been healed with difficulty. This plan Dr. Moxon has tried in three similar cases, in all with a like unsatisfactory result, and now considers the plan useless and unsafe. Bromide of potassium has much benefited the patient; the muscular movement is less, and sleep is now good.

Partial Paralysis of the Legs.—A middle-aged man complains of tight girthing around the loins, and he walks with difficulty, the muscular power of the legs being much diminished. He has been the subject of progressive muscular atrophy in one arm for two years, indicating long-standing changes in the cord. Just before admission, he was thrown from a cart and alighted on his head; the weakness of the legs followed. He has no difficulty in micturition now, though the history shows he had incontinence at first. This fact would be thought by some to be incompatible with genuine paralysis, were he appealing to a jury "for damages in a railway case." It appears, however, that the paralysis of the legs has resulted from the accident, and there is no reason to suspect malingering.

Epilepsy.—A girl, aged 14, has been liable for several years to bouts of epileptic fits, and for such was admitted. An ice-bag to the spine was first used, but without effect. She was then put on bromide of potassium, half a drachm three times a day, without relief; the dose was then raised to one drachm three times a day, and the fits ceased. They have not returned on subsequently reducing the dose.

Pleurisy.—On the physical diagnosis of the effusion, Dr. Moxon remarked that the tactile vocal fremitus is an uncertain guide; it may partially persist with effusion; it may be absent from other causes. Effusion in the left pleural cavity may easily displace the heart towards the median line; but when on the right side, a much larger effusion is necessary to push over the heart, although, on the contraction resulting from subsequent absorption, displacement is greatest in right-sided pleurisy. If, with effusion, the temperature remain above 102° or 103° Fahr. for some days, it is generally purulent. In cases of phthisical consolidation of an apex, there may be pleuritic effusion, which subsequently becomes absorbed and closes up.

Cardiac Jaundice.—A man, aged 21, presents the signs of tricuspid regurgitation. The liver is pulsatile, heaving and pulsating in the epigastrium synchronously with the ventricular systole. He is moderately jaundiced, and *the stools present an excess of bile*, which seems to indicate excessive secretion. Were the jaundice due to catarrh or œdema of the ducts, or to inspissation of bile resulting from defective hepatic circulation, no such excess of bile would appear in the stools. The same thing has been observed in a few other cases.

Typhoid Fever.—A man, aged 20, was admitted in the second week of an irregular attack of continued fever. He had no rash; the temperature oscillated irregularly from 99° to 103° Fahr., generally higher in the morning. During the fourth week of his illness, the fever subsided and the patient began to convalesce. Solid food was now allowed, and shortly afterwards the patient relapsed, with a typhoid rash on the abdomen (which was absent in the primary attack), diarrhœa, furred tongue, and slight bleeding from the nose. The temperature was again highest in the morning, reaching 103° Fahr.; this gradually came down the second week of the relapse. The first attack was not characteristic of typhoid; the relapse was completely characteristic. This favors the doctrine of the possibility of the generation of typhoid *de novo*. A sort of incubation during the first illness seems to have perfected the poison, which was thus able to develop a regular form of the disease in the relapse.

GUY'S HOSPITAL: OUT-PATIENTS (MR. DAVIES COLLEY).

Cyst of the Upper Jaw.—A man, twenty-four years of age, presented a fluctuating swelling of the size of a walnut on the right side of the face half an inch below the orbit. In the mouth, the tumour projected along the outer margin of the gum; it was fluctuating and not painful. This had been noticed during the last two and a half years, and had been lanced twice, when "stuff like coffee-grounds" is said to have been evacuated, but the wound was not kept open. Adjacent to the tumour was a carious bicuspid which had not been tender, but the man had some face-ache three years ago, *i. e.*, before the formation of the cyst. The canine tooth was absent on this side, the lateral incisor being in contact with the bicuspid, and there was no history of its extraction; possibly then the cyst may be dentigerous. There was no discharge from the nose or other sign of disease of the antrum. A seton was then passed through the cyst from the mouth by means of a curved needle, and a clear slightly yellow mucoid fluid was evacuated. A crater of bone was then felt surrounding the cyst at its base. Probably the adjacent carious tooth will have to be extracted. A radical measure would be to lay the cyst freely open and stuff it with lint. A finger in the cyst would enable the diagnosis to be confirmed.

A young woman came under treatment a month ago with a mucous cyst of the upper jaw of two or three years' growth, producing considerable deformity. It had previously been lanced two or three times. A seton was inserted and tied in; clear mucoid matter exuded, suppuration followed; a carious tooth adjacent was then extracted. The patient is now free of all trouble but a depression in the maxillary bone.

Polypus growing from the Septum of the Nose.—A girl, aged 15, had been troubled with obstruction of left nostril and epistaxis for four months. This was found to be due to a pedunculated polypus growing from the septum. In January it was removed under chloroform, and now there is no sign of disease. Polypus growing from the septum is very rare; this one measured a little over half an inch by one-third; it was very vascular, and ulcerated on the surface. Structurally it consisted of a large number of vessels and adenoid tissue, with many lymph cells.

Nævus.—An infant presented a nævus in the centre of the upper lip. A month ago this was injected with pure carbolic acid (liquefied by heat). At present the surface is slightly irregular, in a few places too vascular, and these points may have to be touched with the actual cautery. The nævus, however, is cured, and that without scar or irregularity in the outline of the lip. Mr. Davies Colley usually excises nævi, especially those occurring in parts where the skin is loose, as on the trunk; the margins of the wound then come well together and direct union usually follows; on the lip, however, this would produce a deformity.

A Ganglion of the Wrist had been three times dispersed by pressure, and had reformed. A fortnight ago, it was laid open under carbolic spray, and stuffed with carbolic gauze to excite a little inflammation. This had been removed within four days, and no suppuration followed. The wound is healed and the ganglion apparently cured. Mr. Davies Colley has treated many cases thus without any ill results; but usually the gauze is left in one to two weeks.

Primary Chancre on the Lip.—A young woman had, in some inexplicable manner, contracted a hard chancre on the lower lip. It presented an indurated base, with thickening of the whole lip. There were mucous tubercles adjacent to the primary sore, also superficial ulcers on the tongue and tonsils. No cutaneous rash had followed, perhaps because the patient had been treated with mercury from the first. A similar case of primary chancre on the lip gave a history of having "been scratched by a cat."

Excision of the Hip-joint.—A child whose hip was excised eighteen months ago was carried into the room, with an extension splint *in situ*. The apparatus used was a modification of De Morgan's arrangement, consisting of a lateral splint on each side of the body, interrupted at the hip, the two splints being firmly connected by iron bars passing under the body. The splints were strapped to the body, and loosely bandaged to either leg. Extension was then made by a cord attached to the foot, passing over a pulley at the end of the splint to a spring at its outer side.

Necrosis of the Superior Maxilla, following Smallpox.—A girl, six years old, contracted smallpox three months ago. A month from the onset, two teeth fell out and the breath became foul. About an inch of the alveolar process necrosed, became exposed, and was taken away with the greatest ease. Such a form of necrosis may follow after exanthemata.—*British Med. Journ.*, June 30, 1877.

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Cases of Spina Bifida treated with Iodo-Glycerine Injection.—At a recent meeting of the Liverpool Medical Institution (*Brit. Med. Journ.*, June 30, 1877), Dr. Cormack read the notes of two cases of this affection treated by him at the North Dispensary. The first case occurred in an infant brought to him twelve hours after birth. The child had been a breech-presentation, and the tumour, being mistaken for the bag of membranes, had been ruptured by the midwife in attendance. Leakage was going on when seen by Dr. Cormack, who sealed the opening with a lint-pad and tincture of benzoin. Four days later, the opening closed and the swelling having increased, the tumour was tapped, but only a portion of its contents (two drachms) was withdrawn, and a drachm of iodo-glycerine solution injected (linimenti iodi ʒj; glycerini ℥iij). The opening was sealed, and the whole of the tumour painted over with collodion; after which a pad and bandage were applied. For eight hours afterwards, the child appeared drowsy, vomited a little, and refused the breast. Next day, it appeared well; the tumour was somewhat collapsed towards its centre. On the third day, the swelling was more diminished; the child seemed well, but had occasional twitchings of the muscles of the spine and upper extremities. After this, steady recovery ensued; dressings of lint and tincture of benzoin were used for ten days, and afterwards benzoated zinc ointment. A fortnight after the operation, the swelling had disappeared, and a mere fissure which leaked slightly was left; and, three weeks later, this closed, and the child was dismissed cured. The second patient was brought to Dr. Cormack forty-eight hours after birth; but here there was complete loss of power in the lower extremities. The tumour was situated in the lumbo-sacral region, and the integument at the centre was so thin as to be transparent. It was tapped at its base, half a drachm of straw-coloured serum was drawn off, and half a drachm of iodo-glycerine solution injected (iodi gr. x; potassii iodidi gr. xxx; glycerini ℥j). The case was dressed as in the previous instance; but, before the dressing was completed, the sphincters were relaxed, the temperature fell, the surface of the body became livid, and the child seemed moribund for fifteen minutes, after which it rallied. Next day, the child appeared well; but there had been a few clonic spasms of the upper extremities. The tumour felt consolidated. For ten days afterwards, the swelling diminished; and, at the end of this period, consolidation appeared perfect, except in the centre of the swelling, where fluctuation could be felt. Into this part, therefore, some more of the injection was thrown, when, immediately, convulsions, followed by intense collapse, ensued, and death occurred in half an hour. A *post-mortem* examination of the swelling (nothing further was allowed) showed that it had been converted into a coarse fleshy mass, with a central sac about the size of a hazel-nut, evidently undergoing recent contraction. This sac had a smooth glistening lining, and communicated with the spinal canal. The sac and the substance of the tumour were filled with venous blood, which kept welling up during the examination. The laminæ and spinous processes of the lumbar and sacral vertebræ were absent, as also was the spinal cord below the twelfth dorsal, where it seemed to burst forth into a leash of nerves which lost themselves in the substance of the tumour. Dr. Cormack attributed the fatal result to two causes, shock and venous hemorrhage; one of the meningo-rachidian veins, in all probability, having been wounded. In the course of the discussion which took place, Dr. Barr said he had seen Dr. Morton operate on several of his earlier successful cases, and doubted whether the treatment was desirable where nervous structures were intimately involved in the tumour. In reply to Dr. Cameron, Dr. Cormack said that, in this fatal case, a certain amount of power seemed to be appearing in the lower extremities after treatment.

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Case of Popliteal Aneurism Cured by the Application of Esmarch's Bandage for Fifty Minutes.—Michael M——, aged thirty-six, a grocer, was admitted into Mr. TYRRELL's ward at the Mater Misericordiæ, Dublin, on the 20th of April, with an aneurism of the left popliteal artery. He stated that up to the preceding March he had enjoyed good health, except for a short time in September, 1872, when he had a slight attack of rheumatism. He had been in America for a year, and while there was very intemperate.

On the 10th of March, when kneeling, he was seized with a most violent stinging pain in the back of his left knee. He stood up at once, and the pain ceased until he went to bed, when it returned with increased violence. The pain continued during the night, to disappear again in the morning. On examination, he noticed a small hardish lump in his left ham, but did not feel it throbbing. For about a month after this he continued quite well, except for a dull pain in the left ham which attacked him on and off.

On the 8th of April, as he was returning home from a long walk, he was again attacked with a most violent racking pain, and the lump, which had up to this date been slowly increasing in size, now increased rapidly, and commenced to throb. He painted it with tincture of iodine, and rested for some days; but, not finding himself getting better, he sent for Dr. White. That gentleman, at once recognizing the nature of the disease, sent him to Mr. Tyrrell. There was no history of syphilis.

On examination, a large pulsating tumour was felt and seen in the left popliteal space, measuring five inches from above downwards, and five inches and a half from side to side. It was soft, and a slight bruit was audible with the stethoscope over it. The superficial veins of the leg were swollen, and the whole limb was slightly œdematous. Neither the anterior nor the posterior tibial arteries could be felt on the left side, but were palpable on the right. The circumference of the left knee immediately above the patella was fourteen inches, on the right side twelve inches and a half; half an inch below the patella on left side fifteen inches, on the right side eleven inches. The tumour was principally in the inferior portion of the popliteal space. The heart-sounds were normal. He required large doses of morphia to give ease from the violent pains, shooting from the toes to the hip, which came on at night. He was ordered to remain in bed, and to take immediately a full saline cathartic draught. He was put on a restricted meat diet, got very little to drink, and was allowed ice and oranges to allay his thirst. He had a subcutaneous injection of morphia at night.

On the 24th of April Mr. Tyrrell applied Esmarch's bandage. Commencing at the toes, the bandage was wound tightly round the limb as high as the tumour, then lightly over it, and again up the thigh. The elastic tourniquet was also put on. The patient complained of considerable pain while the bandage remained on, but it was not so severe as to call for the use of an anæsthetic. Mr. Tyrrell allowed the bandage to remain on fifty minutes. On its removal all pain ceased. The tumour had sensibly diminished in size, was quite hard and globular, and had a very slight pulsation. Digital compression was kept up for two hours. When examined at the expiration of that time, the tumour was found absolutely pulseless. As a matter of precaution a compressor was applied over the femoral artery at the pubes, and the patient was directed to keep it moderately tight. After the elastic bandage was taken off, the leg and thigh were enveloped in a flannel bandage and elevated on pillows.

On the 25th April, the patient, having slept all night, said he was free from pain, but complained of numbness in the toes and foot. The articular arteries around the knee could be both seen and felt to pulsate. In the evening pulsation was felt in the anterior tibial on the dorsum of the foot. The tumour felt very solid; no trace of pulsation. Next day the patient was better in every respect; the œdema of the leg was nearly gone, and sensation was normal in the foot. He slept well, and the tumour was apparently smaller. On May 1st the patient got up and dressed himself, and was anxious to be allowed to walk about, but Mr. Tyrrell would not allow this, as he thought it more prudent to rest the leg for some time longer. Ordered a pair of crutches. On May 2d the patient went home.—*Lancet*, June 30, 1877.

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Large Scrotal Hernia in a Young Child; Operation for Radical Cure by Wood's Method.—On June 2, Mr. Wood operated at King's College Hospital, on a case of large scrotal hernia, in a child aged three years. The case presented several points of interest. The appended remarks have an additional value, inasmuch as they give the results of Professor Wood's most recent experiences.

The case was congenital, and no truss was of any avail. The abdominal opening was large enough to admit easily two fingers direct, and very lax. The coverings of the sac were thin and delicate. The case required delicate and careful manipulation from the great tendency of the bowel to rush into the sac under the least strain. The rupture could be returned, and kept up most easily by holding up the little patient's legs and pelvis. The fingers of the assistant were then placed over the hernial opening, while the preliminary incisions were being made. The sutures were then placed securely, and the loop of wire tightened up and twisted, with the effect of entirely closing up the hernial aperture. Pressure was then made by a pad and spica bandage, and the child's knees drawn up and held securely together by a roller.

In his remarks after the operation, Mr. Wood stated that he had now operated in more than 200 cases, but few of them were so young as this case, for the reason that it was found difficult to control one so young during the critical period just after the operation. This case, however, was so severe and uncontrollable, and so certain if left in its present state to disable the patient for life, that an exception was made to the above rule. With reference to the supposed danger of peritonitis, Mr. Wood said that of the three deaths which had occurred in his hands out of the 200 cases, one only was from peritonitis, but even this was found to arise on the opposite side of the abdomen to that operated on, and to have started from a knuckle of bowel which had evidently been in the sac before the operation, and pressed upon by the truss. No inflammation was found in or near the sac operated on. He had found symptoms of peritonitis in not more than 10 out of the whole 200, and then it was usually slight, and confined to the parietal peritoneum. The chief thing was to choose only healthy subjects for the operation, and to be careful to provide a free escape for any discharge which might occur. Usually the after-discharge was very scanty, and consisted chiefly of serum, which crusted the wound. The wire should not be disturbed till a week or ten days had elapsed, and both the doubled ends had ulcerated into the same track or channel. Adhesion and granulation would by this time have matted together and made adherent the inclosed and twisted sac and parietes of the canal. In a severe case the adhesions usually remain for some time delicate and tender, and require support from a well-fitting truss till they are firmly consolidated. In a small and favourable case, however, the sides of the inguinal canal become blended together over and around the spermatic cord, and the natural valvular functions which prevent rupture are restored and maintained. As far as he could follow the numerous cases, he found an average of cures of about 70 per cent. Some had been shown from time to time in the theatre of King's College Hospital after a lapse of eleven, fourteen, and sixteen years; remaining (one under severe tests) perfectly well, and requiring no truss after the first twelve months.—*Lancet*, June 9, 1877.

A Case of Chorea with Typhoid Fever supervening.—Joseph B., æt. 15½, sailor boy, was admitted into Dr. Barclay's ward at St. George's Hospital, on February 28th, suffering with well-marked chorea.

The boy has always been healthy and robust, but has had swollen cervical glands. History of phthisis in the family. Four years ago he had his first attack of chorea, which came on after a fall; it affected the right side only. He joined a training-ship in September, and on the 5th of January he had another attack of chorea, affecting both sides, and due, as he says, to a fall from his hammock, the fastenings of which had been cut by his comrades.

Feb. 28. Choreic movements of both sides, chiefly in the arms; hesitation in his speech. Strumous aspect; long eyelashes, bluish sclerotics, and white, delicate skin. Loud systolic murmur at apex, which is just internal to nipple line. Diastolic murmur over the middle of the heart. Urine normal. He was ordered a jalap and calomel powder, and two drachms of the syrup of iodide of iron three times a day.

March 6. Choreic movements less. Systolic murmur still heard; the diastolic one has disappeared; speech improved; quite quiet when asleep.

17*th*. As the choreic movements did not seem to improve steadily under the iodide of iron, he was ordered two grains of sulphate of zinc every six hours, and this was to be increased by a grain every day. He soon improved under this treatment, and by the 22d he was walking about the ward, the zinc having been increased to a dose of seven grains.

31*st*. The sulphate of zinc, now in twelve-grain doses, was discontinued, as he had a temperature of 103°.8 with dry, coated tongue, loose, light-coloured motions, and a flushed face. Neither pain nor gurgling in the right iliac fossa. He was ordered an effervescing saline containing ammonia, with milk and beef-tea, and no solids. Within the next few days he developed all the symptoms of a mild attack of typhoid—rose-coloured spots, pain and gurgling in right iliac fossa, loose, light motions, dry, coated tongue, with slight delirium at night. The temperature, however, never rose above 105°; it began to decline on the fourteenth day, and became normal on the twenty-first.

During the typhoid attack the choreic movements became very much less, and at the height of the fever the patient was all but quiet. As soon, however, as the fever left him, and he became convalescent, the movements again returned, though not with the same intensity as before. He could speak better, but there was still a tremulous movement of the lips, and his walk was not quite steady. At the present time (May 11th) he is all but well, and is to be sent to a convalescent home.

The origin of the febrile attack is uncertain, as there had been no case of typhoid in that ward for more than three months. No other patient, either in the ward or in the hospital, developed typhoid. He might have been infected before admission; but then the inoculation stage must have lasted over a month, the usual time being from ten to fourteen or even twenty-one days.

According to Trousseau and other writers on medicine, any specific inflammation during an attack of chorea has a tendency to cure the latter affection, and this effect was well shown in the above patient by the marked improvement and decrease of the chorea during the attack of typhoid.—*Med. Examiner*, June 28, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Transactions of the International Medical Congress.—We are informed that the Committee of Publication hope to publish in the month of September the Transactions of the late Congress.

American Neurological Association. — The third annual session of this Society was held in New York on the 6th, 7th, and 8th of June, Dr. J. S. Jewell, of Chicago, presiding. A number of interesting papers were read, and the following officers were elected for the ensuing year: President, Dr. J. S. Jewell, of Chicago; Vice-Presidents, Drs. F. T. Miles, of Baltimore, and S. W. Webber, of Boston; Secretary, Dr. E. C. Seguin, of New York.

Medical Society of the State of New York.—The annual meeting of this Society was held at Albany, June 19, 20, and 21, 1877, the President, Dr. E. R. Squibb, of Brooklyn, in the chair. A number of valuable papers were read, and the meeting was one of the most successful and instructive ever held. The time of holding the annual meeting was changed to the third Tuesday of January.

The following officers were elected for the ensuing year: President, Dr. J. Foster Jenkins, of Yonkers; Vice President, Dr. Augustus L. Saunders, of Brookfield; Secretary, Dr. Wm. Manlius Smith, of Manlius; Treasurer, Dr. Charles H. Porter, of Albany.

Iowa State Medical Society.—The twenty-fourth annual session of this Society was held at Cedar Rapids on May 30th and 31st, Dr. H. C. Bulis, of Decorah, presiding. There were about 130 members present, and the session is reported to have been of more than usual interest.

The following office-bearers were elected for the ensuing year: President, H. Ristine, of Cedar Rapids; 1st Vice-President, Jno. W. Gustine, of Carroll City; 2d Vice-President, L. P. Fitch, of Charles City; Secretary, J. F. Kennedy, of Des Moines; Treasurer, G. R. Skinner, of Cedar Rapids. The next session will be held at Des Moines in February, 1878.

Changes in Insane Hospitals.—Dr. Charles H. Nichols, Superintendent of the Government Hospital for the Insane, Washington, has been appointed Superintendent of the Bloomingdale Asylum, New York, vice Dr. D. Tilden Brown, resigned.

Dr. W. W. Godding, Superintendent of the Lunatic Hospital at Taunton, Mass., has been appointed to the charge of the Government Hospital.

Obituary Record.—At Baltimore, on the 3d of July, in the eighty-first year of his age, Nathan R. Smith, M.D., Professor of Surgery in the University of Maryland.

Dr. Smith was born in New Hampshire, and in 1825 he was elected Professor of Surgery in the University of Vermont. In 1827 he removed to Baltimore, and accepted the Professorship of Surgery in the University of Maryland. He was a popular teacher and good surgeon. His name is probably best known in connection with his anterior splint for the treatment of fractures of the thigh.

FOREIGN INTELLIGENCE.

Podophyllin in Constipation and Hæmorrhoids.—Dr. Rousselet (*Gaz. Méd.*, May 26), on the strength of forty-seven cases, confirms the favourable reports that have been given of the utility of this substance in habitual constipation. He prefers pills of the gum-resin, and is of opinion that the remedy is usually continued for too short a period, two or three months being required to contract the habit of passing a daily stool, which, too, should be always attempted at the same hour. He begins with one pill of a centigramme, adding another, if necessary, and continues this dose daily for a fortnight; after this he gives one every other day for a week, and increasing the interval by a day every week. If the bowels in the mean time act irregularly, he goes back to the daily dose, again to diminish it. He prefers giving the pill with the last meal, instead of at bedtime as usually advised. Having observed hæmorrhoids which so commonly accompany constipation, disappear when this is relieved by the pills, Dr. Rousselet tried their effect on persons who suffered from hæmorrhoids as a substantive affection, giving one or two centigramme pills in the same way. His success has been very considerable, the stools becoming softened, and the pain, tumefaction, and vascular enlargement being promptly relieved. The remedy, however, may require to be continued daily for a month or two.—*Med. Times and Gaz.*, June 6, 1877.

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Applications in Syphilitic Ozæna.—Dr. Mauriac recommends (*Union Méd.*, June 28) the following: Sugar or powdered talc, 10 parts; subnitrate of bismuth, 5 parts; and calomel, half a part; some of this to be sniffed up several times a day. Or the following powder may be employed: Alum and tannin, of each 1 part; powdered talc, 10 parts; and subnitrate of bismuth, 5 parts. If there are fungosities or ulcerations, they may be touched with a pencil of nitrate of silver, or with a solution of the strength of a fifth or tenth. Or the following ointment may be applied: Nitrate of silver, half or a whole part dissolved in a sufficient quantity of distilled water; and cold cream, 20 parts.—*Med. Times and Gaz.*, July 7, 1877.

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The Treatment of Tapeworm. — Prof. Mosler has been advocating a system of treating tapeworm which, according to a Swiss medical journal, has been attended with remarkable success. Its chief characteristic is the injection of large quantities of warm water into the colon, after the administration of the anthelmintic. The diet is first regulated, food being given which is supposed to be distasteful to the tapeworm—bilberry tea, herrings, sour cucumber, salted meats. The intestine having been, as far as possible, emptied by laxatives, a dose of the extract of pomegranate-bark is administered, prepared from the fresh bark, and then a large quantity of warm water is injected into the rectum. The theory is that the worm, previously brought down into the colon, is prevented by the water from attaching itself to the wall, and is brought away by the liquid on its escape. It is asserted that in every case in which this treatment was adopted the head of the worm was removed.—*Lancet*, June 23, 1877.

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Trichinosis in Saxony.—In a "Statistical Account of the Epidemics of Trichinosis that have occurred in Saxony during 1860–75," published by Dr. Reinhard in the *Archiv für Heilkünde*, Band xviii., he furnishes a table which shows that within this period thirty-nine epidemics have occurred, giving rise to 1267 cases of trichina disease, and to nineteen deaths, four of these occurring in males, and fifteen in females. Only a very small proportion of the cases arose from eating raw pork, while one-half were produced by eating smoked sausages (*Knackwürste*), giving rise to, however, only two deaths. Among 340 persons who partook of well-prepared sausages (*Bratwürste*), eight died. The epidemic appeared for the first time in fifteen places, more than once in seven places, and seven times in Dresden. In most instances the number of persons attacked was few, the highest numbers amounting to 209, 140, and 199—one death only resulting from the combined total of 548 cases occurring in these three epidemics. In several instances the number of cases was as low as from one to seven. The mean (thirty-two and a half) of the 1267 cases was scarcely exceeded in a fourth part of the places, while in three-fourths of the other places the mean was not reached. In many instances the number of cases was so small as to show that a trichinized animal may be entirely consumed without inducing the disease at all. The same conclusion is arrived at from the comparison of the number of slaughtered trichinized animals and the number of cases of the disease. It is calculated that 100 trichinized pigs will give rise to only four cases of the disease in man.—*Med. Times and Gaz.*, June 23, 1877.

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Arsenic in Domestic Fabrics.—Dr. Owen Rees, Consulting Physician to Guy's Hospital, has again, through the *Times*, called attention to the subject of arsenical poisoning which is going on largely in the metropolis through carelessness. A lining to curtains, of green calico, was found to contain arsenic, and on the removal of the curtains several patients recovered their health at once. This poisonous lining Dr. Owen Rees says he believes is still selling freely, and is doubtless producing severe suffering. Another source is a green muslin much used for ladies' dresses. Dr. Debus, the Professor of Chemistry at Guy's Hospital, purchased some of this muslin, of a very beautiful pale green, for analysis. It proved to contain upwards of sixty grains of an arsenical compound (Scheele's green) in every square yard, and this was so slightly incorporated that it could readily be dusted out. Dr. Rees thinks cases of this kind call for Government interference, since here is a cause for nausea, vomiting, violent headache, inflammation of the eyes, etc., which can only be removed by stopping the manufacture of these deleterious fabrics. Green is not the only colour to be shunned, unfortunately. Dr. Debus found that red, scarlet, and mauve colours—so much in use, and so justly admired—are sometimes contaminated with the arsenic used in their preparation, the metal not being always properly separated. The atmosphere of the ball-room, for instance, where these fabrics are worn, must be thoroughly impregnated with the arsenic shaken off in dancing; and loss of health and languor at the end of a London season are not always to be attributed to late hours and bad champagne.—*Med. Times and Gaz.*, June 23, 1877.

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Deaths from Chloroform.—The Lancet (June 9, 1877) records still another case. This time it is a patient at the Blackburn Infirmary, who was about to submit to an operation for perineal fistula, and died while under the effects of the chloroform.

The *British Medical Journal*, June 30, 1877, records a case which occurred at Mercer's Hospital, Dublin, on the 25th of that month. The heart was fatty.

M. BACHELET, a young student of medicine, a son of the Professor of History at Rouen, having suffered from an intolerable toothache, endeavoured to allay the pain by taking chloroform; but having swallowed too large a quantity, he almost immediately fell down as an inert mass. Notwithstanding every effort, he shortly after died.—*Med. Times and Gaz.*, July 7, 1877, from *Union Méd.*, June 28.

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Death under Bichloride of Methylene.—A case of this, which occurred on the 16th of June at the East Suffolk Hospital, Ipswich, is reported in the *Med. Times and Gaz.* for June 23, 1877.

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British Medical Association.—The forty-fifth annual meeting of this body will be held at Manchester on August 7th, 8th, 9th, and 10th Dr. Wilkinson, Senior Phys. to the Manchester Royal Infirmary, is the president-elect.

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German Gynæcological Society.—A number of obstetricians having resolved to found a Gynæcological Society, a committee, consisting of Professors Credé of Leipzic, Hecker of Munich, and Hegar of Freiburg, has framed the rules and by-laws, and has just called the first meeting at Munich on September 15 and 16, for the purpose of discussing these, and entering upon the general business of the new society, for which numerous papers have already been forwarded.—*Med. Times and Gaz.*, June 30, 1877.

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University of Edinburgh.—Dr. ROBERT R. FRASER, well known for his important researches on the Calabar bean, has been elected as the successor of Sir Robert Christison, in the Chair of Materia Medica in the University of Edinburgh.

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OBITUARY RECORD.—At Dublin, on the 13th of June, of pleuro-pneumonia, Henry Wilson, F.R.C.S.I., aged 40 years. Although cut off in the prime and vigour of manhood, Mr. Wilson had attained a very prominent position as an Ophthalmic Surgeon. He held the position of Professor of Ophthalmic and Aural Surgery, in the Royal College of Surgeons, and was Senior Surgeon to St. Mark's Ophthalmic Hospital. He is chiefly known in this country as the author of some admirable "Lectures on the Theory and Practice of the Ophthalmoscope," published in 1868.

BELLEVUE HOSPITAL MEDICAL COLLEGE, CITY OF NEW YORK.

SESSIONS OF 1877-78.

THE COLLEGIATE YEAR in this Institution embraces a Preliminary Autumnal Term, the regular Winter Session, and a Spring Session.

THE PRELIMINARY AUTUMNAL TERM for 1877–78 will open on Wednesday, September 19, 1877, and continue until the opening of the Regular Session. During this term, instruction, consisting of didactic lectures on special subjects, and daily clinical lectures, will be given, as heretofore, by the entire Faculty. Students expecting to attend the Regular Session are strongly recommended to attend the Preliminary Term, but attendance during the latter is not required. *During the Preliminary Term Clinical and Didactic Lectures will be given in precisely the same number and order as in the Regular Session.*

The Regular Session will begin on Wednesday, October 3, 1877, and end about the 1st of March, 1878.

FACULTY.

ISAAC E. TAYLOR, M.D., Emeritus Professor of Obstetrics and Diseases of Women, and President of the Faculty.
JAMES R. WOOD, M.D., LL.D., Emeritus Professor of Surgery.
FORDYCE BARKER, M.D., Professor of Clinical Midwifery and Diseases of Women.
AUSTIN FLINT, M.D., Professor of the Principles and Practice of Medicine and Clinical Medicine.
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ALEXANDER B. MOTT, M.D., Professor of Clinical and Operative Surgery.
WILLIAM T. LUSK, M.D., Professor of Obstetrics and Diseases of Women and Children, and Clinical Midwifery.
EDMUND R. PEASLEE, M.D., LL.D., Professor of Gynæcology.
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AUSTIN FLINT, Jr., M.D., Professor of Physiology and Physiological Anatomy, and Secretary of the Faculty.
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EDWARD G. JANEWAY, M.D., Professor of Pathological Anatomy and Histology, Diseases of the Nervous System, and Clinical Medicine.

PROFESSORS OF SPECIAL DEPARTMENTS, ETC.

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JOHN P. GRAY, M.D., LL.D., Prof. of Psychological Medicine and Medical Jurisprudence.
EDWARD L. KEYES, M.D., Professor of Dermatology, and Adjunct to the Chair of Principles of Surgery.
EDWARD G. JANEWAY, M.D., Prof. of Practical Anatomy. (Demonstrator of Anatomy.)
LEROY MILTON YALE, M.D., Lecturer Adjunct upon Orthopedic Surgery.
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A distinctive feature of the method of instruction in this College, is the union of clinical and didactic teaching. All the lectures are given within the hospital grounds. During the Regular Winter Session, in addition to four didactic lectures on every week-day, except Saturday, two or three hours are daily allotted to clinical instruction.

The Spring Session consists chiefly of Recitations from Text-books. This term continues from the first of March to the first of June. During this Session, daily recitations in all the departments are held by a corps of examiners appointed by the regular Faculty. Regular Clinics are also given in the Hospital and in the College building.

FEES FOR THE REGULAR SESSION.

Fees for Tickets to all the Lectures during the Preliminary and Regular Term, including Clinical Lectures	$140 00
Matriculation Fee	5 00
Demonstrator's Ticket (including material for dissection)	10 00
Graduation Fee	30 00

FEES FOR THE SPRING SESSION.

Matriculation (Ticket good for the following Winter)	$5 00
Recitations, Clinics, and Lectures	35 00
Dissection (Ticket good for the following Winter)	10 00

Students who have attended two full Winter courses of lectures may be examined at the end of their second course upon Materia Medica, Physiology, Anatomy, and Chemistry, and, if successful, they will be examined at the end of their third course upon Practice of Medicine, Surgery, and Obstetrics only.

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CLINICS.

CLINICAL LECTURES.

Notes of a Clinical Lecture on some points in the History of Pneumonia, especially its Duration. Delivered at St. Bartholomew's Hospital. By JAMES ANDREW, M.D., Physician to, and Joint Lecturer on the Principles and Practice of Physic at, St. Bartholomew's Hospital.

Gentlemen: I shall not attempt to-day to give you a systematic account of pneumonia or a description of the physical signs. I shall be content to give little more than illustrations of the clinical history of the disease which have recently come under our notice here, and thus help you in some of the difficulties which beset students.

1st. What is pneumonia? Let me tell you what it is not. It is not simply consolidation of the lung tissue. Thus in a patient with heart disease or pyæmia, the physical signs of consolidation of more or less lung tissue are developed; but you have no right whatever to say that he has got pneumonia. Pulmonary consolidation by itself no more proves the existence of pneumonia than a tumour does that of cancer, delirium that of inflammation of the brain, or a high temperature that of typhus fever. Like all other diseases, pneumonia is constituted not by any single symptom, but by the sequence and relation in which certain symptoms occur. It is outside my purpose here to attempt to define pneumonia. You may lay stress upon the febrile movement or

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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the local change, but the essentials of the disease are acute invasion, the invasion being marked by the prominence of certain symptoms, especially rigors and frontal headache, and soon followed by the local signs of pulmonary consolidation. In this respect it differs from pleurisy, in which the local symptoms very commonly precede the general ones. After the febrile movement has lasted from five to eight days—seven days is the most usual period—rapid and complete defervescence takes place, followed by a more leisurely restoration of the lung to a healthy state. Remember, of the two different classes of symptoms, local and constitutional, one is just as necessary as the other. Lung consolidated without a certain type of fever has no more right to be called pneumonia than fever without consolidation. In fact of the two the latter would be nearer the truth. You may be now and then fully justified in making a diagnosis of pneumonia, although none but the slightest, perhaps even no physical signs may be present. In the same way you know that the so-called eruptive fevers, even smallpox, are not always attended by the eruption.

Take the following cases as illustrations of typical pneumonia, especially in respect to its duration.

George B., æt. 9, admitted April 12th; consolidation of left lower lobe, with great pain, which was relieved by one or two leeches. Illness began on April 7th. On April 12th the evening temperature was 102°. On the morning of April 13th, *i.e.*, on the seventh day of the disease, it had fallen to 98°.

Joseph R., æt. 8, admitted on May 5th, with a temperature of 103°.5. On May 6th, in the afternoon, it was still 102°.2; at midnight it was 98°.6. He had been taken ill on April 30th, therefore defervescence occurred on the seventh day.

Patrick M., æt. 13, admitted May 18th, with a temperature of 101°.6. This comparatively low temperature was probably due to the cooling effect of his removal to the hospital, for on the same evening it rose to 103°, and he became delirious. On May 19th, his temperature fell to 96°.4. His illness had begun on May 14th, and had thus lasted six days; the left lower lobe was the part affected.

John R., æt. 5, pneumonia of the left lower lobe. Taken ill on May 18th, admitted on May 21st, with a temperature of 103°. The fever subsided suddenly on May 28th, the eleventh day of the disease.

Remember, I am only giving you illustrative cases, not attempting to prove an already well-established fact by statistics; and please notice that in all the defervescence was final, followed by rapid and complete convalescence, whilst the youth of the patients and the probable soundness of their organs at such an early age justify us in supposing that we have here instances of the simple, uncomplicated type of pneumonia.

Unfortunately, we know too well that pneumonia does not always run this favourable course, that defervescence may be deferred indefinitely, and that it often ends fatally. What are the conditions which interfere with the favourable history of the disease? Remember again, if you please, that I am giving only illustrations, not statistical proofs.

Charles H., æt. 49, pneumonia, right apex; subject to cough for some years, but never spat blood; admitted on April 21st, his illness having begun some six weeks previously. Up to April 28th his temperature was about 101°, on that day it became normal and remained so, but on May 23d, notwithstanding progressive improvement in the physical signs and general condition, there were still at the right apex some impairment of resonance, coarse respiratory murmur, and occasional crepitation.

John N., æt. 31, a drunkard, died three days after admission with consolidation of the right upper lobe. At the autopsy, the lung was found in part gangrenous, but there were no traces of chronic disease.

These two cases illustrate the danger of apex pneumonia, and also, perhaps, the causes of the gravity of this form of the disease.

The apex is the favourite seat of chronic changes more or less serious, and thus great additional embarrassment is caused by the occurrence of acute consolidation;

and next, the apex is probably more liable than the base to the serious forms of acute as well as of chronic disease. But you must not suppose that the apex pneumonia is always of abnormal type. We had, not long since, in Mark ward, a case in which defervescence took place on the seventh day. The first condition, then, which I have to mention as interfering with the natural course of the disease, and prolonging or rendering it especially serious, is the occurrence of consolidation at the apex.

Next, remember that the prognosis as to the duration of the disease is always unfavourable if there be much pleuritic effusion in its earlier stages. True, pleurisy is almost always present, but I am speaking now not of mere inflammation of the visceral layer of the pleura over the consolidated portion of lung—often, by the way, the cause of severe pain—but of effusion into the pleural cavity; of cases, that is, in which you find the physical signs of fluid as well as of solid lung. Of this class of cases we have lately had several in the hospital. I shall content myself by just mentioning two. In one death took place after three months' illness; in the other, imperfect defervescence at the end of three weeks was followed slowly by protracted convalescence. In these cases the febrile movement is kept up, not by the pneumonia, but by the pleurisy, *i.e.*, by the spread of the inflammation, set up at first by a specific cause, to neighbouring tissues, just in the same way that ulceration in the intestines in typhoid fever, and in the neck in scarlet fever, spreads to the cellular and other tissues contiguous to the glands at first affected.

Again, the violence of the pneumonic inflammation may completely destroy the vitality of the parts affected. Generally this proves fatal, as in one of the cases already mentioned; sometimes, if the patient survives, it leads to the rapid formation of a large cavity. There is a case of this kind at present in the Mark ward. The patient, a man, æt. 26, who has suffered from no previous illness, will tell you almost the exact spot in a court out of Fleet-street where, whilst coming from his work, he was attacked some eight weeks ago by violent rigors and frontal headache, soon followed by cough. On admission, some six weeks afterwards, he had the physical signs of the lung breaking down at the right apex, and soon there were the usual signs of a cavity, among others, the so-called cracked pot sound. For some little time the cavity increased almost daily in size; it is now contracting. The moist sounds are disappearing, and his general condition rapidly improving. At the same time, however, the heart is becoming gradually displaced to the right. These cases are much more common, at least in my experience, in children than in adults, and often lead to great displacement of the heart. It may be, however, that it is not the form of disease but the recovery which is more common in childhood.

I tell you that pneumonia is an acute specific disease, or, at any rate, that it deserves the name as much as scarlet fever, typhus, erysipelas, or smallpox; and further, that it most distinctly belongs to the class of diseases which have a definite duration; the termination of a pneumonia can be predicted as successfully as that of typhus fever. But you must not suppose that there are no transitional forms, no links between it and other forms of disease. Here are two illustrations of what I have ventured to call transitional forms. A girl, æt. 18, was admitted about twelve months ago into Mary ward with pleuro-pneumonia of the left side, pericarditis and albuminuria, and we never succeeded in ascertaining which of the local diseases began first. Again, only last week I saw a hardworked clergyman who two years ago, under close and highly-skilled observation, had consolidation of the right lung and albuminuria, apparently beginning simultaneously with the usual symptoms of pneumonic fever. Now in these cases I hold, with Dr. Basham, that the pulmonary consolidation and the nephritis are co-ordinate effects of one general change. But this does not hold good absolutely in cases such as the following. A man, æt. 23, was admitted about six months ago under my care with pneumonic fever and consolidation of the lower part of both lungs, but he had previously had scarlet fever, followed by dropsy, and the pneumonia began with its usual symptoms during the dropsy.

Again, consolidation of the lung, attended by increase of febrile movements, frequently occurs in connection with rheumatic, typhus, and typhoid fever, and from these it is but an easy step to the same event in pyæmia and heart disease. Now in these two latter cases we have seldom, if ever, the right to use the term pneumonia, and yet it is difficult to say at what precise point in the series it ceases to be applicable.

Let me say just a word or two as to some of the causes of pneumonia, and with special reference to its specific character. First, it is a disease of the spring and early summer months; it may be that this is due to the greater liability to chills which the increased day heat brings with it, or that there is some more general atmospheric condition which predisposes to it.

Next some cases of pneumonia are most certainly pythogenic in origin. I have myself seen two remarkable series of cases in which it was impossible to doubt that defective sewage was the cause; and during this present spring a friend of mine at Dorking has met also with a series of six or seven cases depending upon the same apparent cause. Sometimes mere irritating vapours develop constitutional and local disturbance, closely simulating pneumonia. Thus I have had under my care a patient who, after exposure to the vapour of strong liquor ammoniæ, had consolidation of one lung, with marked febrile movement.

We have no time to-day for any detailed discussion of the treatment of pneumonia. I wish to impress two things only upon you. Don't over-treat your patient—you can no more cure the disease than you can cure typhus fever or smallpox; he will get well when the disease reaches its period if your over-activity does not prevent it. And lastly, do not over-examine your patient—the harm done by frequent elaborate examinations will most certainly overbalance any good you or he will derive from them.—*Med. Examiner*, July 12, 1877.

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Notes of a Clinical Lecture on Acne. By Jonathan Hutchinson, F.R.C.S.—When the face is covered with pimples, some of which are red, some contain pus, and others show only black points in their centres—all kinds being present, and all slow in progress—it is commonly agreed to call the condition Acne. If the spots are angry and suppurate quickly, it is acne pustulosa; if they are small, very florid, and not prone to suppurate, it is acne rosacea; if there is great thickening about them, and again little tendency to suppurate, it is acne tuberculata; if there are numerous black points to be seen, it is acne punctata; lastly, if no one of these features be in excess of the others, it is common acne—acne vulgaris. Now, let us first understand clearly that these various adjectives do not denote different diseases, but merely different conditions of the same disease, which may be frequently met with in one and the same case. Next, we will observe that all forms of acne are inflammations of sebaceous follicles. I have already said that, when a follicle inflames, three results ensue—a thickening of its gland tissue, deposit and congestion of the cellular tissue around it, and accumulation of its secretion in its interior. Now, we have in acne all shades of variety as to these three results. Every one is familiar with the little black dots so frequent in the skin of the face of those who have rather coarse complexions. In degree they may perhaps be found in the skins of most persons, especially about the nose. If you squeeze them, little black-headed "maggots" are ejected. These maggots, or grubs, are not living, but consist of half-dried sebaceous matter, which had accumulated in the cavity of the gland, and which has been moulded into the pellet form in passing through the constricted opening. The black head is the end of the pellet, which, having been long exposed at the mouth of the duct, has gathered soot.

It is not always that the end of the pellet gets blackened; sometimes, and especially in young persons, the mouth of the follicle is closed by a delicate membrane, and then the secretion collected beneath it is seen under its transparent covering, and remains quite white. In infants this distension of closed follicles constitutes what used to be known as strophulus albidus; in adults it is more frequently seen on the eyelids than on other parts.

Sometimes the interior of the follicle suppurates, and, after removal of the pellet, pus escapes. This constitutes pustular acne.[1]

It is a peculiar feature of the condition known as acne, that at one and the same time, in the same patient, you will find the follicles in all stages of disease, some simply distended and free from material irritation, others congested also, others suppurating. In this it differs much from lichen.

Acne is emphatically a disease of coarse skins; or rather, perhaps, we ought to say that the term "coarse skin" usually applies to integument in which the sebaceous follicles are larger than ordinary, and have gaping mouths. This causes the skin to look rough and pitted. It is a state of skin the tendency to which is often hereditary, and it is thus often seen in several members of the same family.

Acne spots cause more annoyance on the face than elsewhere, and hence an exaggerated impression as to their great relative frequency on this part. Although there is no doubt that the face and shoulders are their usual sites, yet, if you will examine the general surface of acne patients, you will very frequently find the spots, in smaller numbers, on the trunk and the upper arms also.

Having asserted that all persons of coarse skin are liable to have their sebaceous follicles take on occasionally the acne inflammation, we may suitably ask what are the causes which induce the more severe forms of the disease. For clinical purposes we may recognize acne chiefly in two forms—first, the acne of young persons; and second, the acne of those past middle life. It is in young persons that we meet chiefly with the pustular, punctate, and vulgaris types, whilst in the elderly we encounter the acne rosacea and tuberculata. Respecting the acne of the young, there is a very widespread opinion that it is usually the result of sexual disturbance. I have no doubt that this belief is well founded to some extent, but we must beware of exaggerating it. The eruption is chiefly met with in young celibates, whilst it is very rare under the age of puberty, and is often benefited by marriage. It is possible, however, that its comparative rarity in the married may after all be a coincidence and not a sequence, and that we ought to consider it not so much a disease peculiar to celibacy as to the special age at which a large majority of the population are celibates. It may certainly occur before puberty. I have seen it not very infrequently in children, and once in a very marked form in the face of an infant of six months. It is also frequent in married persons of both sexes, and sometimes originates after marriage. I have known it occur in ladies who were bearing children, and in whom the sexual functions appeared to be in perfect activity.

Making full allowance for a considerable number of acne cases in which there appears to be no sexual cause, there are yet, I think, good grounds for accepting the general belief that in a majority of instances such is the fact. The remarkable influence which the sexual functions exercise upon the general health and upon the state of the nervous system is amongst the secrets known unto all men. That they should have the power of making the sebaceous glands of the skin enlarge and suppurate is certainly, if thought about, one of the most strange. I suspect that, when it occurs, it is brought about through the agency of the nervous system rather than of the blood. Women who are not liable to acne at other times sometimes have a few spots appear at each menstrual period, and that whilst in excellent general health. I have been assured by gentlemen liable to nocturnal emissions that they invariably had an increase of acne spots after such occurrences, and sometimes so immediately, that it was impossible to believe that any material change in the blood had occurred. In other cases sexual intercourse may produce the same result.

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[1] By some authors called Milium *seu* Grutum.

It is certainly not in cases of extreme sexual exhaustion that acne is most common. I have seen many such patients, both with and without spermatorrhœa, who had not a spot of acne, but, on the contrary, had skins which were perfectly smooth — in some instances florid, in others earthy pale. It is, perhaps, rather a condition of sexual irritability than of exhaustion which produces acne. I do not think that the severity of the acne eruption bears any relation to the degree of sexual disturbance. In the worst cases that I have seen the patients often seemed to be in good health.

To dismiss the subject, we may remark that the prescriber ought, in respect to the acne of celibates, to bear in mind the possibility of a sexual cause. He will advise the adoption of measures likely to improve the general vigour, he will caution against any possible causes of debility, and he may, in some instances, suggest matrimony as the remedy most likely to prove successful. Derangements of stomach and liver stand in about the same relation to the acne of middle-aged persons that sexual causes do to the acne of early life. Manifest dyspepsia (often the result of intemperance) is present in perhaps half the cases of acne rosacea, whilst in the other half it is exceedingly difficult to assign any cause. The same remark applies also to the indurated and tuberous form of acne, which produces the thickened, bossy condition of skin familiarly known as "grog-blossoms," and usually considered to be proof of intemperance. In many cases such suspicion is most unjust. At any rate, of this you may be sure—that in persons congenitally of coarse skin very slight indulgence at the table may produce results in the way of acne, which would not ensue in others whatever the amount of provocation afforded. As I asserted in reference to sexual exhaustion, so I may say here again, it is common enough to see the most intemperate escape scot-free. Nothing would be more unjust than to allow ourselves to entertain the belief in the one form of acne, that it is certainly due to sexual causes, or in the other that intemperance or gluttony is the cause. We will freely admit a frequent connection, but strongly deny that it is invariable. For the worst forms of acne of either variety you will be able to discover in the patient's state of health or antecedents no cause whatever, and you will be compelled, in considering your measures of treatment, to regard it chiefly as a local disease.

The rules for the constitutional treatment of acne patients follow easily from what we have said. If the patient be young he should be made to use a cold bath every morning, to take plenty of exercise, to live liberally as regards meat diet, with a fair allowance of stimulants; and he should be cautioned or encouraged, as the case may be, in reference to sexual matters. As to medicines, a long course of small doses of arsenic will often be of great use. If constipation be present, the habitual use of a chalybeate aperient should be prescribed. You may do all this, however, most sedulously, and gain nothing whatever, if you neglect local measures; whilst with the latter only, and without any change in the patient's habits, you may often get an acne eruption so nearly well that he will regard it gratefully as a cure. The chief local measure consists in destroying, by means of a fluid caustic, the inflamed follicles. With a fine-pointed glass brush, or a bit of soft wood cut to a point, you touch the inflamed spots from day to day. Take great care not to apply too much. In the left hand should be a roll of blotting-paper with which to absorb the fluid if it has been deposited too abundantly. The best fluid to use is the acid nitrate of mercury. It will usually be necessary to repeat the touching once a week for a month or two, carefully seeking out every fresh spot. After that the patient should still see you once a month, in order that the cure may be kept up. The acid thus used does not leave larger scars than the spots would themselves do.

In acne rosacea the use of the caustic

will again serve an excellent purpose. You may not only touch the spots themselves, but also pencil out the stray vessels which add so much to the patient's disfigurement. He, or more usually she, will gladly exchange a few slight and scarcely perceptible scars for the angry and very suspicious-looking redness of face which the disease causes. — *Med. Times and Gaz.*, July 28, 1877.

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Treatment of Phthisical Cavities.—In the course of a clinical lecture on Excavation of the Lung in Phthisis (*Lancet*, August 4, 1877), Dr. R. Douglas Powell, Physician at the Brampton Hospital for Consumption, said: I purposely avoided saying anything about the treatment of *contracting cavities*, for I believe that there is nothing special to say about them. There is one point, however, as regards the management of cough in these cases that may be mentioned. It often happens that the patients, long accustomed to expectorate easily, complain of "tightness" of the chest, and dry, teazing cough. This cough must of necessity be allayed by the free use of cough mixture, but the patients should at the same time be directed to restrain, as far as possible, by an effort of the will, the cough, which by its rending action tends to disturb the healing process going on in and around the cavity. We must do what we can to keep the patient in his favourable condition of general health; we must watch for, and by timely treatment subdue, catarrhs, or, still better, if possible avoid them by judiciously-selected climates. We can give no medicine that will directly hasten the contraction of cavities. In some cases we may try by the selection of high climates to encourage the more rapid expansion of the opposite lung.

In the treatment of *secreting cavities*, the objects we have in view are (1) to lessen secretion, (2) to promote evacuation of what secretion is formed, and (3) to disinfect such cavities. Counter-irritation—of little use, I believe, whilst cavities are still forming or extending—is of great service in these cases. When we remember that in chronic excavation of the lung we almost invariably get an intimate union of the two pleural surfaces and an anastomosis of their vessels, we may see why the application of a blister externally may affect such cavities. As a matter of fact, they do influence them most decidedly. Strong iodine applications (two drachms to the ounce), or flying blisters, or perhaps a blister kept open for a few days by the use of savin ointment dressing, are the forms of counter-irritation suitable to different cases. Under their use the cough and expectoration frequently diminish. Acids and astringent iron tonics and oil are needed. Sedative cough mixtures are directly contra-indicated in these cases, except for the purpose of giving rest at bedtime. It is in these cases that inhalations are most useful; for, firstly, there being no actively spreading disease present, they can do no harm; secondly, we can by their use render less noxious the pus that bathes the surface of the cavity, and which is apt to become inhaled during the effort of expectoration into distant parts of the lung; thirdly, inhalations help expectoration; fourthly, there can be little doubt that appropriate inhalations sometimes have a healing or an alterative effect upon the internal surface of the cavity.

The best substances for inhalation are —iodine (vapor iodi B. P.), only to be used occasionally and for a few days together; carbolic acid (glycerine of carbolic acid, one drachm to two drachms, to half a pint of hot water); or tar water (liq. carbonis detergens, one drachm, to half a pint of hot water); useful disinfecting and, except iodine, somewhat sedative inhalations, that may be employed two or three times a day. They may be taken very well from a deep jug or a Nelson's inhaler with the sponge removed. Friar's balsam, tincture of larch, turpentine, etc., may be similarly employed from time to time. Perchloride of iron or other astringents may sometimes be used with Siegle's spray apparatus; but I have myself failed to find atomized astringents useful in these cases, and doubt if they penetrate so far as vapours inhaled in the ordinary way. Sea air, and perhaps especially sea-shore air, containing more or less salt spray, is usually beneficial to these patients. A liberal diet is of course necessary.

Cases of *active or ulcerous cavities* may require at first the free administration of alcoholic stimulants; a somewhat liberal allowance of wine is also subsequently needed, with nutritious support and abundance of good air. These active or ulcerous cavities tend to become endemic in over-crowded wards, and their occurrence should always lead us to look to sanitary arrangements, for their pathology strongly suggests their erysipelatous nature. It cannot, indeed, be too carefully remembered, in the treatment of patients with phthisical affections of the lungs, that they have internal wounds or sores, which, unlike most other internal affections, are accessible to the contamination of foul air, and that thus erysipelatous processes may be readily set up which are too apt to be recognized only as "intercurrent pheumonias" or other local inflammations.

Medicinally these cases may be combated by quinine internally, or in some cases full doses of perchloride of iron; sedative inhalations, containing tincture of benzoin and opium, hyoscyamus and chloric ether, carbolic acid and opium, etc., are useful. Ipecacuanha wine, administered as spray with Siegle's inhaler, is worth a trial, but patients suffering from this condition of cavities are often too prostrated to bear the fatigue of inhaling. If the more active general symptoms should lessen, but a blood-stained and copious expectoration still leads us to infer that the walls of the cavity are hyperæmic, I am convinced from observation that the best treatment is to apply a blister over the region of excavation, and to keep it freely discharging for several days by means of savin ointment dressing. I have seen the active symptoms completely subside under this treatment—which is, however, somewhat severe and painful—and the cavity subsequently contract, the expectoration, from being abundant and sanguineous, becoming scanty, viscid, and apparently consisting of bronchial mucus only.

Attempts have been made from time to time to treat lung cavities, on surgical principles, as local abscesses, by evacuation of the matter from without, or by the injection of astringent or disinfecting solutions. Dr. Mosler, in the *Berliner Klinische Wochenschrift* for October, 1873, relates three cases which he has treated in this way. In the first two cases he indroduced a small canula into the cavity, and daily injected a small quantity (twenty cubic centimetres) of permanganate of potash solution without causing any serious inconvenience. In a third case he introduced a silver drainage-tube into a large cavity, through which much discharge escaped. After six weeks the patient had slight hæmoptysis, and a weak solution of perchloride of iron was injected, and subsequently a pulverized weak solution of carbolic acid and iodine were blown through the canula. The patient died at the end of three months of amyloid disease of organs.

Dr. Wm. Pepper, of Philadelphia, has treated three cases by the injection of astringents through a fine Dieulafoy's needle, in one case, he states, with positive improvement. He suggests that hæmoptysis should be treated in this way.

These procedures, and others of a like kind, can only as yet be regarded as tentative, and as useful in showing what *can* be done if necessary in cases of the kind. So far as we can see at present, however, cases must be extremely rare in which such treatment would be likely to prove useful. It sometimes happens, however, that a cavity is situated quite at the base of the lung, and the removal of secretion from it is extremely difficult, attended with vomiting and great distress; portions of the irritating matters from the cavity are inhaled into the bronchial tubes of the other lung, setting up fresh inflammatory centres there. In these cases the cavity, being at the lowest point of the lung, might well be treated as if it were a pleural abscess.

HOSPITAL NOTES AND GLEANINGS.

Hospital Notes. King's College Hospital: Dr. Johnson's Wards.

Stricture of the Œsophagus.—A woman, forty years of age, and markedly emaciated, complained of great difficulty in swallowing. Her illness commenced four months previously to admission, with difficulty in deglutition, which had gradually increased, and during the last three weeks she had become rapidly worse, so that she was able to swallow nothing but a little milk and beef-tea, and had suffered much from hunger. An œsophageal bougie, when passed, met an obstruction opposite the thyroid cartilage, and could not be passed further. There was no difficulty in respiration, and the lungs and heart presented no signs of disease. On laryngoscopic examination, a white mass was seen situated between the larynx and pharynx. She frequently complained of pain towards the left side of the larynx. As the stomach-tube could not be passed, a No. 10 elastic catheter was used, and this easily slipped past the obstruction. The stomach-pump was then attached to the catheter by means of a piece of elastic tubing; and strong beef-tea, eggs, and milk, etc., were injected. This method of feeding has been repeated at intervals, and has been followed by a considerable amelioration of the patient's condition.

Dr. Ferrier: Out-Patient Department. Hemichorea. — A woman, twenty-three years of age, complained of a troublesome jerking of the right arm, often, she said, as violent "as if it would tear out the arm from its socket." This illness followed her confinement six weeks ago; she had never had chorea previously, but seven or eight years ago she was attacked with "rheumatics," which, however, did not prevent her moving about. A sister, aged twenty-eight years, had, while pregnant, been attacked with a fit, followed by general and violent chorea; there had also been considerable mental disturbance after her confinement, necessitating her removal to an infirmary. The patient was much distressed and frightened by her sister's illness; and three days after her own confinement, which was long and trying, choreic movements commenced in her left arm and leg; these have been accompanied by burning sensations in the left side of the body and in the back. Muscular power was much diminished in the left hand, but there was no anæsthesia. When the woman held out her arms, constant irregular movements were seen in the left arm and hand; so also with the left foot and leg when the patient sat down and held out both feet. The left side of the face twitched somewhat, and, when standing erect, the body swayed from side to side. There were no signs of heart-disease. Dr. Ferrier considers that the pathology of chorea has yet to be made out, and is not much inclined to give credit to the theory of embolism or thrombosis. In the course of Dr. Ferrier's physiological experiments, a monkey, in whom the lateral portions of the cerebral hemisphere were exposed, became choreic on the opposite side of the body, and subsequently developed epileptic convulsions. The symptoms of chorea differ from those of sclerosis in being more constant and irregular, not simply coming into prominence when a voluntary effort is made, as in sclerosis. In paralysis agitans, again, the movements may be described as constant and vibratory in character. The patient was ordered liquor arsenicalis.

Cutaneous Hemianæsthesia.—A woman of nervous manner complained of numbness of the left side of the body, arm, and leg; also of "flushing heats." When her eyes were shut, on touching with a needle the corresponding points on the two hands, she said she did not feel the touch on the left side; but if the needle perforated the skin, she could feel the prick. Similar anæsthesia was found in a less marked degree on the left side of the face. Sight was equally good on both sides. Hearing, as tested by the watch, was fair on both sides, rather more acute in the right ear. A vibrating tuning-fork, placed on the bridge of the nose while the woman closed her ears, was longest audible in the right ear. The sensibility of the tongue, both to touch and taste, was diminished on the left side. Smell was tested by holding tincture of assafœtida to each nostril alternately, the eyes being closed; the patient seemed hardly to perceive it at the left nostril. Taste and tactile sense appeared to be diminished on the left side of the tongue. The woman was also liable to attacks of headache, with dysæsthetic ocular phenomena, described as "wheels of brightness." She suffered from dysmenorrhœa and slight menorrhagia; no abnormal condition of the uterus was found, but there was marked tenderness in the left ovarian region. As usual in cases of neurosis dependent upon ovarian irritation, there was tenderness over the fourth dorsal vertebra. Dr. Ferrier expressed his belief that many cases of hemianæsthesia would be found if they were more frequently looked for. In this class of cases, hystero-epilepsy (Charcot) is frequently met with, and such attacks may often be arrested by firm pressure over the ovary affected.

Cross Paralysis.—A woman, aged 32, was attacked last January with a fit, accompanied with loss of consciousness; the face was drawn to the left side, and the left arm and leg were paralyzed both as to motor power and sensibility; she also lost the power of speech for a week. When examined, on making her show her teeth and by watching the features while she was speaking, it was evident that the *right side of the face* was partially paralyzed, especially in its lower parts, while the left arm and leg were much weaker than the right. This condition of hemiplegia on one side, with paresis of the face on the other side, both having occurred at the same time, indicated a probable lesion in or near the pons Varolii.

Facial Neuralgia. — A woman, forty-three years of age, of nervous temperament, complained of a sense of oppression at the back of her head and violent facial neuralgia, accompanied with loss of sleep. This appeared to have followed the mental shock and depression due to the illness and death of her mother. She was ordered bromide of potassium.

Fits, with Disease of the Heart. — A woman, aged 40, complained of attacks apparently epileptoid, and attended by partial syncope; consciousness was lost in these fits, and there was struggling; sometimes the tongue was bitten. Examination showed signs of both aortic and mitral regurgitation. There was no family history of neuroses; and cerebral anæmia, due to the defective circulation, appeared to be an important element in the causation of the attacks. Dr. Ferrier ordered a mixture of digitalis and bromide of potassium, and remarked that while the bromide would lessen the conductivity of the nerve-fibres, as indicated by its action in rendering the mental powers dull, the digitalis would render the nervous centres less excitable to reflex action, and increase the muscular strength of the heart.

Mr. Wood's Wards. Sarcoma of the Lower Jaw.—A man, thirty years of age, was operated on a month ago for the removal of a tumour of the lower jaw. A single semilunar incision was made in the line of the lower jaw, the saw was then applied to the bone behind the lateral incision, and, by reflecting the face upwards, the bone was removed with the tumour. The mass proved to be a mixed form of sarcoma, consisting partly of round cells and partly of spindle cells. The tongue was not involved, and the features were but little disturbed. The man is now convalescent, and there is as yet no sign of return of the disease.

Impermeable Stricture of the Urethra.—A man, the subject of a stricture of long standing, was admitted to the hospital with complete retention of urine. The attempt to pass a catheter was made, but failed. A hot bath was used without relief. To relieve the urgency of the case, a fine aspirator needle was passed into the bladder, above the pubis; 36 ounces of urine were thus drawn off. The smallest size elastic catheter was then passed into the bladder, without the stilette, and tied in. Hot fomentations were then applied, and an aperient draught ordered, to be followed by a sedative draught of morphia.

Strumous Disease of Joints.—A lad presented strumous disease of the wrist-joint, and phthisical changes in one lung. The joint was painted with iodine and placed on a straight splint; the hand was then placed in a sling, ice being at the same time constantly applied by means of an ice-bag hung round the boy's neck.

Salicylate of Quinine, in doses of two to five grains, is being tried by Mr. Wood in cases of chronic suppuration attended with high temperature; the results have yet to be observed.

Recto-vaginal Fistula.—The woman, in her last confinement, was delivered by forceps, three times applied during labour. No immediate ill results followed, and she convalesced; at the end of a fortnight, however, sloughing occurred. When admitted to hospital, the recto-vaginal septum had almost entirely disappeared; a fistula also opened from the bladder and urethra into the vagina. The edges of the fistula were pared, the adjacent mucous membrane was dissected up, a median flap was drawn over the opening, while lateral flaps were united over this by means of wire sutures. There has been no sloughing, and the patient is doing well. Great attention has been paid to cleanliness, and the patient has been kept in the prone position, in order that the urine in the bladder may be prevented from finding its way through the fistula.

Amputation of the Foot; Quick Recovery.—Mr. Wood amputated a boy's foot for disease of the ankle-joint. Dry dressings were applied; union occurred by the first intention, and he was discharged within three weeks of the operation; in another fortnight he was walking about. No special antiseptic method was employed, but great attention was paid to cleanliness.—*British Med. Journ.*, Aug. 4, 1877.

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Lymphadenoma of the Pelvis; Hœmaturia; Transfusion; Death three days subsequently.—E. T. C., aged twelve, was admitted into Albert Ward, St. Thomas's Hospital, under the care of Mr. Sydney Jones, on April 16, 1877. He stated that he was quite well until one month ago, when he was kicked in the perineum by another boy. He suffered no pain at the time, but two or three days afterwards pain of a dull, heavy character gradually came on, which was worse at night and on sitting down; this interference with sitting was the first thing noticed by the mother. There was no pain on defecation, but the pain kept him awake more or less. The swelling first appeared, about a week after the pain, as a hard lump the size of a hazel-nut, situated in the middle line behind the anus, but it was never tender at any time; this increased in size until, on admission, it occupied the whole breadth of the perineum, extending from about half an inch in front of the anus to the tip of the coccyx. There was no history of any tumours in the family.

On April 17 the boy was examined by Mr. Sydney Jones, under chloroform. The rectum was surrounded, except in front, by a hard, smooth, new growth. The upper limit could be felt at the extremity of the forefinger as a rounded, defined ridge. The coccyx moved with the tumour. The abdomen was very thin, allowing the spinal column to be felt easily. Ordered twenty drops of the syrup of the iodide of iron twice a day.

May 5. The skin covering the tumour was of a dark-red colour. Complained of much pain in his back. Motions passed involuntarily.

6*th.* Subconjunctival hemorrhage in right eye.

8*th.* Rectum again examined under chloroform, and tumour found to have increased considerably in size, having encroached more upon the rectum, so that the finger was very tightly grasped. Upper limit could only be reached with difficulty. An enlarged gland discovered in the right groin, very large and prominent. (A slight trace of this was felt on April 17.) The abdomen was found to be extremely tense, due to a distended bladder. Urine drawn off by catheter. Mr. Jones thought that patient's countenance suggested hemorrhagic diathesis.

11*th.* On the patient attempting to get up, it was found he could not stand; his legs gave way under him, and he had to be carried back to bed. When in bed he could draw up both his legs, but complained of much pain in the left leg, and also of a feeling of pins-and-needles. On examination, a dark-blue mottled patch (hemorrhagic) was observed on the outer side of the thigh, extending nearly its whole length. Ordered morphia injection. The mother stated that his father is subject to epistaxis.

Although catheterism had been necessary for the last week, on the 14th water was passed freely. A prominence was discovered over the first or second sacral vertebra, and a spot of extravasated blood over it. He complained of feeling unable to move his legs; he could, however, draw them up, but seemed to have lost a great deal of control over them, so that the last part of flexing his thighs was apparently quite passive, the thighs falling helplessly on to the abdomen. The left leg was bandaged from the foot upwards.

15*th.* Patient looked worse, and extremely anæmic. No further retention; abdomen tympanitic. Motions passed involuntarily up to the 11th inst.; voluntarily since. Gland in right groin no larger; five or six small flat round swellings, about the size of peas, discovered this morning lying under, but not adherent to, the skin of abdomen, also one on left thigh. Some hemorrhage over right tibia, and also a few other spots of hemorrhage in various places. Loss of control over both legs much more marked. Some œdema of scrotum and feet. It was thought desirable to try the effect of transfusion.

16*th.* Seen by Mr. S. Jones with M. Roussel, the latter performing transfusion at 2 P. M. Cephalic vein opened, and about five ounces of healthy blood injected from the median cephalic vein of Mr. Leatham, one of the students. Before the operation, respiration and pulse were very rapid; during transfusion the boy complained of being unable to breathe, and the cheeks became more rosy. A small pad of oiled lint was placed over the wound, two harelip pins securing the edges. After operation he was removed to bed, wrapped in blankets, and had hot-water bottles applied. 3.20 to 4 P. M. More or less rigors. Complaining of feeling cold; no vomiting. 4.15. Temperature in mouth, 98.4° F. After taking some hot tea and brandy he began to get a little warmer, the colour returning gradually to his lips and cheeks. Involuntary passage of feces; no blood. 4.45. Complained of curious sensations all over, looked frightened, screamed, and tried to throw the bedclothes off, saying he felt so hot. Passed six ounces of urine deeply coloured with blood, uniformly mixed, after which he appeared easier. Respiration rapid. 5 P. M. Temperature in axilla, 105.4°. Great thirst. 6 P. M. Perspiring profusely; restless and irritable. 7.15 P. M. Much cooler; lies quiet and apparently easier; less thirst; lips again blanched. Respiration 48; pulse 108. 8.15 P. M. Has twice passed urine deeply coloured with blood; motions passed voluntarily. 9 P. M. Temperature 100.4°. 11 P. M. Sick for the first time, vomit being of a sour odour, but without bile or blood. Passed a small quantity of urine, bright-red, but less dark than the last three times.

17*th.* Temperature, 9 A. M., 103.2°. Had two rigors very early this morning. Water passed freely, and each time becoming less red. Took some solid meat for dinner. Complained of headache during the morning; restless and irritable at times. Temperature, 10 P. M., 99.2°. Wound dressed, and looks healthy; some oozing through the bandage.

18*th.* Temperature 98°, 2 A. M. Slept well, and seems much better altogether. Stronger, but still very anæmic. Vomited twice during the night. Passed water freely without blood, but once had a little discomfort before micturition. Complains of headache, and no appetite. Temperature 98°, 8 P. M. Ordered five drops of tincture of perchloride of iron every six hours. The bandage on left leg, causing him discomfort, was removed.

19*th.* Passed a very bad night. About 12, complained of difficulty of breathing. This morning suffering from great dyspnœa; nares dilated; lips livid; countenance dusky. Perspiration 58; pulse 120; carotids pulsating forcibly. Had muscular tremours affecting all the muscles of his right leg. Complained of pain all over, especially at the back of his neck and at the lower dorsal region. Wound on arm dressed; edges gaping and bluish-looking. Dyspnœa gradually increased, with great restlessness; screaming with the pain in his back, and died at 12.30 P. M.

Autopsy —A tumour was found in front and at the sides of the coccyx. The growth presented the ordinary characters of lymphadenoma, consisting of a coarse retiform connective tissue, with small somewhat irregular cells in its meshes. It filled the ischio-rectal fossa, and caused protrusion of the anus and neighbouring skin; from the anus it extended to a point two and a half inches above, where it terminated in a well-defined border; above this the tissues were brawny and infiltrated by a similar growth. The tumour firmly embraced, but was loosely attached to, the rectum. Extending upwards into the abdomen from the tumour was a chain of enlarged glands. On cutting through the muscles lying on the left side of the spine, on a level with the sixth dorsal vertebra, a mass of new growth, about the size of two hazel-nuts, was found; also, on the same level, between the coverings of the cord and the spinal canal, was another mass of new growth. In the walls of the heart were two or three small masses, also spots of ecchymosis. No emboli. Left lung œdematous; right healthy; small extravasations in both. Kidneys anæmic; on the left side the straight tubes were in places filled with blood. Under the mucous lining of the bladder was one spot of extravasated blood about the size of a pea. Ecchymosis in both retinæ, and the anterior part of both hemispheres of brain. Suppuration in both tonsils.—*Lancet*, July 21, 1877.

MEDICAL NEWS.

ORIGINAL ARTICLE.

Death from Gunshot Wound after an interval of Fourteen Years. By R. S. **Keeler**, of Phœnixville, Pa.—The length of time intervening between the date of injury and the death of the patient, as well as the peculiar course taken by the ball, renders this case one of considerable interest.

I was called, on December 25, 1876, to see Mr. J. L——, who stated that he had been wounded at South Mountain, on September 14, 1862, and that his wound had never healed, because the ball could not be found. Upon examination I found a wound in the abdomen, upon a level with the anterior-superior spinous process of the ilium, and at a point midway between this process and the linea alba. The patient informed me that pus had never ceased to be discharged from this wound, and that he had also secured thirty-two sequestra of different sizes. Although he had been probed repeatedly by several surgeons, no traces of lead could ever be detected. When I first saw him, he was suffering from hectic, and complained of intense pain upon the inner side of the thigh and leg. I did not think operative interference advisable at that time; hence I endeavoured to improve his general condition by constitutional treatment. Despite every effort, however, he failed rapidly, and died on January 10, 1877. I made an autopsy on January 12, and found that the missile, entering at the point already indicated, on the right side, struck the crest of the ilium, which it shattered. It then passed downward and forward, finally lodging upon the ramus of the ischium in the obturator foramen. The crest of the ilium was much thickened, and extensively necrosed upon its inner surface. The ball, when found, was much corroded and distorted in shape, weighing but six drachms, though we were able to identify it as a round ball of an ounce and a half weight. It may also be stated that there was no evidence that the ball had ever been encysted.

DOMESTIC INTELLIGENCE.

Canada Medical Association.—The tenth annual meeting of this Association will be held in the city of Montreal, on Wednesday, September 12, 1877.

American Public Health Association.—The fifth annual meeting of this Association will be held at Chicago, on Tuesday, September 25, 1877.

Minnesota State Medical Society.—The ninth annual meeting of this Society was held at St. Paul, on the 18th and 20th of June, Dr. F. H. Milligan, of Wabasha, presiding. The following officers were elected for the ensuing year: President, Dr. Otis Ayer, of Le Sueur; Vice-Presidents, Drs. C. P. Adams, of Hastings; A. C. Wedge, of Albert Lea; and E. E. Collins, of Minneapolis. Treasurer, Dr. S. B. Sheardown, of Winona; Secretary, Dr. C. H. Boardman, of St. Paul.

Illinois State Board of Health.—The people of Illinois are to be congratulated upon the enactment by their last Legislature of a bill to establish a State Board of Health. The Board has organized by the unanimous election of Dr. J. H. Rauch, of Chicago, as President and Acting Secretary—a selection which gives great promise of the future efficiency of the Board.

Bromide of Ammonium in Hay Fever.—Dr. E. C. Seguin, of New York, reports (*Journal of Nervous and Mental Diseases*, July, 1877) that last year he induced two or three persons suffering from this disease to employ a strong gargle of bromide of ammonium, and to wash out the nasal passages with a weak solution of the same salt several times a day during the attack. The result was so gratifying that he is disposed to ask physicians to give a fair trial to this treatment during the coming summer and autumn. The gargle to be of the strength of ʒj or ʒij of bromide to ℥j water; the solution for the nares much weaker, of from 10 to 30 grains of bromide in ℥j water.

Honour to Physicians of Pittsburg.—During the recent severe experience of the Philadelphia militia at Pittsburg, whither they were sent by the Governor of the State to aid the constituted authorities in suppressing the railroad riots, and while the citizens of that place generally appeared to be inimical to the troops, the first of the few who promptly came forward with friendly offers of food and personal aid were members of the medical profession. We are gratified to be able to record this to their honour, upon information derived from an official source.

Obituary Record.—At Hanover, New Hampshire, on August 10th, Alpheus Benning Crosby, M.D., aged forty-five years.

Dr. Crosby held the Professorship of Anatomy in Bellevue Hospital Medical College, and was a son of the late Dr. Dixi Crosby, of New Hampshire.

FOREIGN INTELLIGENCE.

Slow Pulse. — M. Rendu brought a labouring man, aged thirty-eight, before the Lyons Medical Society, as exhibiting a remarkably slow pulse, viz., 41 to 42 per minute, no difference being, however, notable whether he was in the erect, recumbent, or sitting posture. The man, who was robust and in perfect health, had applied for some trifling ailment. Not only is the case interesting on account of the slow pulse, but because it proves an exception to the rule laid down by Graves, that whenever there is no appreciable difference in the pulse in the different positions of the body, there is always hypertrophy of the heart accompanied by dilatation. Graves only met with six cases in which the difference was not observable, and in all these this lesion was present. However, in the present case there is no sign whatever of disease of the heart. — *Med. Times and Gaz.*, July 14, 1877, from *Lyon Méd.*, July 1.

Hay Fever.—A correspondent of the *Lancet* (July 21, 1877) says that an ointment of one grain of morphia, ten grains of quinia, and three drachms of spermaceti ointment, when smeared on the inside of the nostrils in small quantities, relieves the irritation consequent on hay fever.

Fetid Feet.—In an article in the *Révue de Thérapeutique* it is stated that an immediate remedy for this noisome affection is found in washing the feet with a solution (1 in 100) of chloral, and keeping them enveloped in compresses wetted with the same solution. Results as satisfactory have long since been obtained by Dr. Bourdon by the employment of a solution (commencing with 3 in 1000) of the permanganate of potash. Dr. Berthold also indicates an efficacious method which is less troublesome than that of bathing with solutions. It consists in powdering the interior of the patient's socks with a powder composed of one part of salicylic acid and five of starch. This is, too, an excellent mode of treating the local sweating which in fat persons often takes place between the scrotum and the thighs, and if not arrested leads to a troublesome eczema, and its accompanying pruritus.—*Med. Times and Gaz.*, August 4, 1877.

Death from Milk in the Trachea.—At the Geneva Medical Society, Dr. ODIER related (*Lyon Méd.*, June 24) the case of a boy about four years of age, who, while taking some milk at table, sank his head and became suddenly pale, death taking place in two or three minutes without struggle or cyanosis. At the autopsy a small fragment of bread was found in the epiglottis, and at the bifurcation of the bronchi there was also found a little bread softened with milk, but which in no wise obstructed the bronchi. A little lower down in the bronchi there were also fragments of the same of the size of a pin's head. Death in this case must have taken place from syncope, and not from suffocation. The heart and lungs were quite healthy, and there were neither subpleural ecchymoses nor bronchial foam. Dr. D'Espine referred to the rapidity with which asphyxia occurs in children who have undergone tracheotomy on the escape of the canula, so that death is imminent unless this be instantly replaced. Dr. Juillard met with the case of an infant at the breast found dead in its cradle. Some coagulated milk was found in the trachea, but not in sufficient quantity to produce obstruction. Dr. Prévost believed the mechanism of death in these cases is similar to that produced in animals by stimulating the central end of the inferior laryngeal, which arrests the diaphragm and respiration. In these cases there may be a similar reflex action due to the foreign body conjoined with the spasmodic element.—*Med. Times and Gaz.*, June 30, 1877.

Death from Chloroform.—A death from chloroform occurred at the Toronto General Hospital on July 18. A woman, aged twenty-five, was about to be operated upon for some uterine trouble, and but a few drops of the anæsthetic had been given when she suddenly died. She had taken chloroform previously and had no unpleasant symptoms. At the *post-mortem* fatty degeneration of the right ventricle was assigned as the cause of death. —*Canadian Journ. of Med. Sci.*, Aug. 1877.

The *British Med. Journ.* for August 4 reports the death from chloroform of Sarah Crudge, aged 23. The anæsthetic was administered for an operation for strabismus.

Colour-blindness among Railroad Employés.—An optical examination has been ordered by the Minister of Ways and Communications, at St. Petersburg, of all persons connected with Russian railways, in order that their power of distinguishing colours may be tested. It appears that this order has been issued in consequence of the startling results lately obtained from a similar examination of railway *employés* in Finland.—*Med. Examiner*, July 19, 1877.

We hope that railroad managers in this country will immediately profit by this experience and example.

Dr. Lewis A. Sayre in London.—We learn from the English journals that Dr. Sayre has been giving demonstrations at the London hospitals, of his mode of treating Pott's disease, and lateral curvature by suspension and fixation. The *Lancet* (July 14) says: "We are not blind to the fact that much of the success obtained is due to Dr. Sayre's own rare mechanical and manipulative skill, but his principles are as sound physiologically as their application is mechanically expert, and we thank him most heartily for the trouble he is taking in England to illustrate and enforce them."

Dr. Edward Warren.—Dr. Warren (Bey), of Paris, formerly of North Carolina, has just received the Cross of Chevalier of the Order of Isabel the Catholic, as a recognition of his professional services to Spanish personages.—*Lancet*, July 14.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Reduction of Strangulated Hernia. Delivered at St. George's Hospital, by TIMOTHY HOLMES, F.R.C.S., Surgeon to, and Lecturer on Surgery at St. George's Hospital.

We have had two cases of strangulated hernia in this hospital within the last week, one of which was reduced without an operation, and the other by extra-peritoneal operation. I propose to-day to speak to you first of the causes of difficulty in reduction, and then of the ways in use for facilitating it.

The main causes of difficulty in reduction are, first, the sudden forcing out of a coil of bowel through a small ring, the bowel afterwards becoming inflated by secretion of gas and fluid. The same may happen with omentum, which becomes congested with blood and thickened by extravasation, and so swollen. Many herniæ are thus strangulated which, though of the congenital form, occur non-congenitally, and many non-congenital herniæ of sudden formation. The next cause of the difficulty in reduction is some irritable condition or spasm of the muscles connected with the hernial aperture. Then we have changes in the contents of the tumour from secretion into the bowel, or from accidental malposition or implication of the contents with each other. These are cases in which reduction is exceedingly difficult, and in many cases is entirely impossible, unless the sac be opened

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Other herniæ become irreducible in consequence of irritation or swelling, or commencing inflammation, or actual inflammatory change and matting together of the tissues which either form the ring or the neck of the sac, or both of them. Here is a beautiful specimen in which the hernia was reduced *en masse*, and in which the patient in consequence died with the strangulation still unrelieved, and you may see quite distinctly that the strangulation is in the sac itself. In a case of that kind reduction by operation would obviously have been utterly impossible except by opening the sac. Then, again, there are cases in which the hernia is, in all probability, entirely irreducible, in consequence of chronic changes in the omentum which forms the hernia. This has, perhaps, been in the sac for years, and the patient has either worn no truss at all, or, what is still more likely, and still more unfortunate, he has worn an ill-fitting truss upon the projecting hernia, and in that way has irritated it, and has caused it to become enlarged and thickened, and so irreducible. Here, again, is a hernia in which the contents of the sac are irreducible in consequence of adhesions which have formed between the omentum and sac. The sac and hernial contents have formed an organic connection, and nothing except the division of these bands of organized adhesions can by any possibility enable you to reduce the hernia. And here, too, is another case of a still more formidable nature, which I remember occurred in my practice when assistant surgeon here—a case of enormous inguinal hernia which had been for many years irreducible; a portion became strangulated, and very difficult indeed it was to see which portion it was in which the strangulation existed. But you see a number of coils of intestine all adherent to each other, and to the sac, so that no dissection which it was justifiable to undertake would have enabled one to reduce the intestine into the belly. These preparations and observations illustrate to you the main causes of irreducibility in strangulated hernia. You must remember that irreducibility and strangulation are different, but I am not going into that subject now. I am speaking of cases in which the hernia is both strangulated and irreducible, and the obstacles to reduction are mainly those which I have pointed out.

Now, with respect to the methods by which surgeons endeavour to meet these obstacles. The taxis is of course the thing first employed. I will not go into the question of position—of turning patients on their head, etc. All this seems to me to depend upon an entire, I will not say ignorance, because that would be rude, but an entire forgetfulness of the obstacles which there are to reduction. Gravity is no serious obstacle to reduction. I do not think putting a man on his head makes his hernia a bit more reducible than putting him on his heels. It does not appear to me that you get any advantage by raising the feet, still less by raising the whole body up altogether so that the man stands on his head; because though you certainly may get some slight advantage from the traction of the bowels which are inside the belly pulling down the bowel outside it, yet you lose a great deal more from the spasmodic condition into which you throw the muscles of the lower extremity and the abdominal wall. It seems to me an entire mistake to waste time upon any of these things. The taxis is the plan which you have first to employ, and that of course aims at neutralizing the first of the obstacles that I mentioned. When the bowel or the omentum has been suddenly protruded through the ring as I have said, the first effect of strangulation upon it is to cause a great increase of bulk by the secretion of air and fluid into the bowel, by the secretion of exuded matters into the tissue of the omentum, and by the detention of blood in both of them. Your object is by gentle pressure to empty the bowel of air and fluid, to empty the vessels of blood, and to push back some of the contents of the hernial tumour through the ring; and the first thing that enables you to be certain that you will succeed in that, is feeling a little air or fluid gurgling back into the cavity of the abdomen. You saw a case a few days ago of a young man who had had inguinal hernia some time, and had not taken much notice of it, till on some violent exertion the inguinal hernia protruded, and at once became acutely strangulated. He was brought in here in great pain. A good deal of vomiting had taken place before admission, and in fact things looked rather bad. There was a very tense tumour, without any impulse on coughing, but we succeeded quite easily in reducing it; by putting the man under chloroform and making gentle pressure, in the course of two or three minutes it went up. And I knew it would go up as soon as I began to handle it, by feeling a little air gurgling out of the hernial tumour into the abdominal cavity. In a case of that kind it would not have been justifiable, if I had failed to reduce it, instantly to have gone on to operation. It seemed to me the strangulation, although acute, was so recent and the symptoms altogether so incipient, that I determined, if I failed in reducing it, to have put him into the warm bath, and to have waited, at any rate, a good many hours, and to have made renewed attempts at taxis, before proceeding to operation. Taxis is very much assisted by chloroform, and I think much more assisted by chloroform than by ether. I do not myself recognize that very great difference in the danger of anæsthesia from chloroform and from ether which some surgeons profess to feel. It seems to me that complete surgical anæsthesia is always a dangerous thing, whether produced by chloroform or ether; and I think chloroform produces so much more complete relaxation, and that so much more speedily, that it is very much more convenient in the reduction of dislocations and strangulated hernia.

But although our horror of repeated manipulation in attempting taxis may have been a little exaggerated by cases which we have seen of severe injury to the intestine by the taxis—cases which I would venture to hope are somewhat exceptional—at the same time I do not think that too prolonged or too frequently repeated efforts at taxis are desirable. I think that Professor Gross, of Philadelphia, has erred somewhat on the other side in stating that almost all herniæ may be reduced by repeated manipulations. It seems to me that when vomiting is distinctly declared, and has turned from bilious vomiting into vomit mixed with the contents of the small intestine—what is sometimes called fecal, although it is not fecal, but where the vomit has turned from the green colour of bilious vomiting to the dirty brown of the contents of the small intestine—then you had better not wait any longer; if you cannot by a renewed attempt at taxis reduce the hernia, you must operate. But that is an interval which allows you a considerable amount of time. You do not, usually speaking, get that condition of things until after twenty-four hours of strangulation, and if you have the patient under your care during the whole of that time there is no reason why you should not put him once, if not twice, under the influence of chloroform, and attempt taxis. Besides, you should put him into a warm bath for a considerable time, or apply fomentations for several hours before you begin to think of the *ultima ratio* of an operation. Ice is frequently used, but seems to me to be very seldom of any use, except in those cases of inguinal hernia in which the tumour is voluminous and evidently contains hardly anything except intestine, and that very much distended with air. In these cases you will find the application of ice of considerable utility.

There is another method that has been proposed for the reduction of hernia, and that is by the aspirator. Dr. Dieulafoy spoke of the aspirator at first as being almost free from danger in these cases; but that certainly seems not to be the case. The object of the aspirator is to empty the bowel, or sometimes you do not perhaps puncture the bowel, but merely empty the sac; more generally you puncture the intestine, and draw off a good deal of gas and a certain quantity of fecal fluid. The puncture in the intestine will be but small. It will be immediately closed by the slipping upon each other of the three coats of the intestine, so that when the aspirator is withdrawn the intestine will no longer have a hole in it. The three holes in the three coats will not correspond, and you can very frequently reduce the hernia afterwards. It has appeared to us at this hospital to be a method which is dangerous, and so doubtful that we have not as yet ventured upon using it; but at the same time it has been used elsewhere in many cases, and its use would be most indicated in the case of a voluminous hernia in which ice is used. So much for the ordinary methods of reduction which precede the application of the knife.

The warm bath has been lately disused at this institution; at least I think I am right in saying so. I certainly have not used it for some years. Sir James Paget, however, recommends it to be used "in all cases that are not very bad;" that is to say (as I think he explains in another passage) in all cases in which you do not think the operation is absolutely indispensable at that moment, and in many of these cases you would not use taxis at all. In many cases in which you think the case is so bad that an operation cannot be put off even a few minutes, you would also think the matter had gone on so far that you had better not handle the gut in any way. The best way is to cut down into the sac at once and investigate the condition of things. It certainly appears to me that Sir James Paget is right in that respect, that in most of these instances you wait a few hours, and if you wait a few hours I cannot help thinking the patients sometimes are a good deal relieved; the muscular spasm is considerably relaxed, and the hernia made very much more reducible by the old method of applying a warm bath, and I must say I rather regret it has so much gone out of fashion at this hospital. I will try at any rate in my own practice to bring it in again. Our plan when I was a student used always to be to put the patient into a hot bath, make him entirely faint, and then try to reduce the hernia. Sir James Paget directs you to use the bath only moderately warm instead of hot. I confess the old plan still seems to me the best. One knows the extreme relief that the hot bath pushed to faintness gives in cases of descent of a stone from the kidney, and also in the case of a gall-stone; and we have often seen the same relief in cases of strangulated hernia.

Now I come to the main point, about operations with or without opening the sac. The case I have to direct your attention to to-day is that of a woman, æt. 50, a laundress, who was admitted with a strangulated femoral hernia on the evening of the 6th June. She was very well nourished, and had never had anything serious the matter with her before. Three years ago, while working hard at her occupation, she felt a sudden pain and found a hard swelling in the right groin. She kept her bed two or three days, and the swelling disappeared, and she thought no more about it. On the evening of the 5th of this month she went out for a long walk, over-exerted herself, came home, went to bed, and found a swelling again in the right groin. She began to have frequent attacks of vomiting, and was admitted into the hospital. I was sent for, but by accident I did not receive the message, and did not see her till the following morning. She had had frequent attacks of vomiting; the substance vomited was of a dark green colour, at first solid, that is to say mixed with food, but afterwards much more watery, showing the commencement of copious secretion from the bowel. On seeing her, and failing to reduce the hernia under anæsthesia, it was obvious that the best thing was to operate without further delay. On cutting down on the sac I found I could pass a director underneath Gimbernat's ligament with great ease, and thought I would try the effect of Petit's operation, which consists in dividing the parts external to the sac, where you can find them most tense. This part in a femoral hernia will be pretty sure to be Gimbernat's ligament, the deep crural arch, and the upper cornu of the falciform opening, which three structures meet together at the upper aspect of the femoral ring. When you can find a tight band lying outside the sac in that situation, an incision will liberate those three great ligamentous structures, and you can then sometimes succeed in reducing the hernia. That was the case in this instance. On making an incision and passing up the finger so as to see that the ring had been entirely free from constriction outside the hernial sac, the tension disappeared, and very slight manipulation succeeded in putting the bowel back. That was on the 7th. The patient had no symptoms at all except slight vomiting after the operation, due merely to the influence of the ether. She had a tolerably good night. There was a little retention of urine, which is so common in women after operations for hernia. A little suppuration occurred in the small wound made, but that was of no importance whatever, and on the 11th, as she was suffering from a good deal of distress from constipation and foul tongue, I gave her a slight aperient, three grains of calomel, followed by a common injection. The bowels operated immediately, and she has since been perfectly well. The wound is beginning to heal rapidly, and she may be pronounced to be out of danger.

That is a very simple example of the extra-peritoneal operation. It is an operation you do not often see here, and I think a somewhat erroneous view, but a view that I cannot say is very erroneous prevails as to our treatment in this hospital. It is said in many quarters that the extra-peritoneal operation is never performed here. That is not true, because I have a note here of seventeen cases in which it has been performed; but it is perfectly true that it is very rarely performed, and the rarity may be judged of in this way. Mr. Haward wrote a paper on this subject in the first volume of St. George's Hospital Reports (1866). I had written a paper some time previously, with Mr. Cooper, showing that out of 121 cases of strangulated hernia in four cases the operation without opening the sac had been performed, and I see all four cases were under Mr. Cutler's care, and all recovered. When Mr. Haward wrote, the number had risen up to 181 cases, and the number of cases without opening the sac only up to six. Again, I wrote a paper in the second volume of the Hospital Reports based upon the notes of 200 cases of operation and then as many as fourteen had been operated upon without opening the sac. And now, when we have had about 374 cases of strangulated hernia, I find seventeen have been operated upon without opening the sac. You see, then, that the operation is rarely practised in this institution, and I must say I do not quite understand why this is so, except from the tendency to routine; for our experience in this operation has been remarkably successful, if you compare it with the ordinary experience of strangulated hernia. Of these seventeen cases of hernia, one was umbilical, and strangulated umbilical hernia is a peculiarly fatal form. That one case died. The cause of death was supposed to be peritonitis, though I believe no opportunity was afforded for post-mortem examination. Of the other sixteen cases only two died. One, which was a case of inguinal hernia, under Mr. Henry Lee's care many years ago, died of suppuration in the scrotum and I think erysipelas, that is to say of one of the ordinary complications of wounds and of nothing specially connected with hernia. The other case, also under Mr. Henry Lee's care, a case of double femoral hernia, died from peritonitis, verified by post-mortem examination. Those are roughly the heads of our statistics of operations for strangulated hernia without opening the sac. There are very few of them, only seventeen, and I think one might exclude the case of umbilical hernia, because umbilical stands on quite a different footing from femoral and inguinal hernia; and if you do so, you see that of sixteen cases of inguinal and femoral hernia operated upon, only two died. That is very different from the statistics of ordinary operations for strangulated hernia, for from 1852 to 1877, 357 cases have been operated upon, in which the sac was opened; and of these 218 recovered, and 139 died. Whilst our operations without opening the sac have given only one death out of eight, in the others the deaths have been more than one-half of the recoveries. I do not say that is a fair comparison, and none of these statistical comparisons are fair, because they omit to take into consideration that which is the essence of the whole thing, namely, what were the circumstances of the case. Of course, these sixteen cases I have been speaking to you about, in which the sac was not opened, were the most promising cases, and in most of them recovery might have been anticipated from the beginning. They were cases in which the symptoms were not very acute; there was really no very great hurry about the matter, and many people would have said it was doubtful whether, after all, the hernia could not have been reduced by taxis. At any rate, they were the most favourable specimens, whereas all the unfavourable specimens go into the other category. You will find the same objections might be made to all statistics which are not based upon notes of cases, for surgical statistics not based upon notes of cases are absolutely worthless if you intend to found any definite practical conclusions upon them. That was the vice which was so patent in the statistics on which Sir James Simpson ventured to found a charge of general unhealthiness against all London hospitals, a charge which was absolutely untrue; it was founded upon nothing except a mass of figures not supported by notes of cases, and figures under such circumstances seem to me merely misleading.

In order to settle what the value of this operation without opening the sac would be, you would want a long series of cases of hernia of about similar gravity—fifty on either side might be sufficient. Say you had fifty cases in which the strangulation had not lasted over forty-eight hours, all treated by the extra-peritoneal operation, and you had to compare them with another series of the same gravity, treated by the intra-peritoneal operation; if you could see that the mortality after the intra-peritoneal operation was not greater than the mortality after the extra-peritoneal operation, say they were both one in eight, then I should say you had succeeded in showing that there was no importance whatever in the matter, that whether you opened the peritoneum or not was of no importance, and every surgeon would say, "It is safer to open the peritoneum and look at the bowel." But that has never been done yet, and until it has been done this matter will not be settled. If you read Mr. Haward's paper, which is a most interesting one, and which is by far the most able argument I know of in favour of the course pursued in this hospital, you will see what advantage he attributes to the operation of opening the sac. He says, "The foregoing remarks demonstrate, I think, that the advantages of the operation in which the sac is opened are certainly greater than those which pertain to that in which that structure is not incised." He argues frankly in favour of opening the sac in all cases, attributing to the intra-peritoneal operation the following definite advantages: "1. That the condition of the intestine can be accurately determined, and that therefore there is less danger of returning a gangrenous intestine; 2. That it insures the detection of constriction of the bowel by adhesions, omentum, or thickening of the sac; 3. That the fluid in the sac escapes externally, instead of being pressed into the abdomen; 4. That there is less danger of wounding the intestine; and, lastly, that it is less fatal." Those are the conclusions to which he comes with respect to operations by opening the sac as compared to the operation without opening the sac; but I confess it does not seem to me, with all possible respect for Mr. Haward, and fully allowing, as I do allow, that our operations by opening the sac are as good in their results as those of other institutions, from which a long series of extra-peritoneal operations have been published, it does not seem to me to settle the question; it does not seem to me you can settle the question till you have got the notes of cases compared as I have suggested, that is to say, similar cases treated differently. You could then see whether in each series composed of similar cases the mortality would be greater or less; and I undertake to say that the mortality of the extra-peritoneal series would be less. At least I am very strongly impressed in the cases which I have seen with the simplicity of the extra-peritoneal operation, and the utter absence of complications of all kinds; so that I cannot help thinking it must be less dangerous in cases to which it is suitable, and if I had the task imposed upon me of answering this paper of Mr. Haward I should say in the first instance, that it is true that the condition of the intestine can be more accurately determined by opening the sac; but that you ought never to employ the extra-peritoneal operation in any case in which there is the slightest reason to suspect gangrene or ulceration of the bowel. If the strangulation has lasted long enough to justify you in thinking about gangrene, you ought never to perform Petit's operation. The second consideration urged by Mr. Haward—viz., that the surgeon is able by opening the sac to detect constriction of the bowel by adhesions, by omentum, or thickening of the sac, is also true; but it is equally true that you cannot reduce the hernia when it is in that condition without incising the sac, at least you cannot reduce it without an amount of violent pressure which is altogether wrong. If you look at the lecture of Sir James Paget on this subject in his recently published Clinical Lectures, you will see there some very good observations upon the fact that if you find any difficulty in reducing the bowel without opening the sac, you ought not to persevere in the attempt too long; if you do, you will in all probability set up a good deal of suppuration and inflammation around the sac, as well as do other and graver mischief. I believe it has been known that the bowel has been ruptured in these cases. The second observation of Mr. Haward, then, is perfectly true; but it may be met by saying that you ought not to insist upon the operation with so much violence as to run any risk in your attempts at reduction. Then, as to Mr. Haward's third argument, that the fluid in the sac escapes externally instead of being pressed into the abdomen. Since Mr. Haward started the idea, it has been made use of as a main argument in favour of the operation by opening the sac. It is said you let out all the foul fluid that is in the hernial sac, whereas, if you operate without opening the sac, you reduce that along with the other contents of the sac into the peritoneal cavity, at the risk of setting up peritonitis. I confess that I can hardly bring myself to believe in the danger of pressing back the fluid in the hernial sac, because I have seen a great number of cases in which the hernia has been reduced by taxis after a length of constriction quite as great as that in which the extra-peritoneal operation has been used, and in these cases no peritonitis took place. Peritonitis hardly ever takes place after the reduction of hernia by taxis; it does sometimes, but very rarely. I have noted one case in the Hospital Reports, and I think it is the only one I ever saw in which, after the successful reduction by taxis of a hernial tumour, peritonitis set in and proved fatal. The rarity of such cases proves that there is seldom little danger in reducing the fluid along with the bowel. After all, the fluid is but the secretion of the bowel; and if there is no danger in reducing the bowel, why should there be any danger in reducing the fluid. It will be soon absorbed. It does not seem to me that this idea is supported by experience. Then, Mr. Haward says that there is less danger of wounding the intestine, and that is also the conclusion of Mr. Hancock; but I cannot think that there is much danger of wounding an intestine in operating outside the peritoneal cavity. There ought to be really more danger in operating inside the cavity. A little care will usually succeed in keeping the bowel and everything else entirely out of the way, and, as a fact, wound of the bowel is very rare in any form of operation.

Then, to say that the intra-peritoneal operation is less fatal seems to me to be just what you want to prove. It is not proved, I think, by the statistics that Mr. Haward produces. As those statistics are my own, I am bound to speak of them with a certain amount of respect; but they only show, that in a long series of cases mixed up altogether, the percentages were about the same—about thirty per cent. in one case, and thirty-three in the other. That does not show to me that one operation is less fatal than the other; it only shows that there is no very great difference. It does not show anything accurately with respect to the treatment of given cases. I must say my own feeling is strong in favour of using this operation more freely than we have done; for we have been a little led away from the true point, which is not whether it would make any vast difference in the statistics of a long series of cases but whether it would save a few lives. If you restrict Petit's operation to those cases of strangulated hernia in which the symptoms are less grave, in which the strangulation has lasted only a short space of time, and in which there is no reason to apprehend any serious mischief to the bowel, I rather think you would succeed in the course of some years in saving a few lives which might be lost by peritonitis following upon the opening of the hernial tumour. That is my own impression; but I only give it you for what it is worth, having no very extensive experience of the operation, and I would say, having been taught entirely the reverse doctrine. I shall therefore be disposed, in whatever opportunities happen to come before me, to employ Petit's operation more freely, and make it the rule than the exception, of course restricting it to the cases I have just mentioned. —*Med. Examiner*, July 26, 1877.

HOSPITAL NOTES AND GLEANINGS.

Tumour of the Lower Jaw removed without External Wound.—Ellen M., aged 33, was admitted into Mr. MAUNDER's Ward, at the London Hospital, on June 4. About December last, the patient first noticed a small swelling of the gum, near the back teeth, on the right side of the lower jaw. She thought it was merely a gumboil; it was neither tender nor painful, and its colour was of a reddish tint. When the tumour had been growing for about two months, the patient sought advice of her doctor, who strangulated it with catgut, and a piece of the growth came away. This operation was performed a second time, and another piece removed. After this two decayed teeth were extracted. The skin opposite the seat of the tumour had been painted three times daily with tincture of iodine, which seemed to retard the growth. The mass was always hard, and the patient could even masticate portions of her food on this side. Occasionally it bled a little.

On admission, the right cheek of the patient bulged outwardly, and, on looking into the mouth, a reddish growth, the size of a large walnut, occupying the site of the molar teeth, was visible. It was painless, hard, and smooth, much resembling gum-tissue.

On June 6, the patient being under the influence of an anæsthetic, and conveniently placed in a dentist's chair, the mouth was held open with a gag. A knife with a rounded end, guided by the tip of the left forefinger, was made to divide the soft parts over the anterior margin of the ramus just about its junction with the base of the bone, and then the periosteum and muscular attachments on both sides were separated with a raspatory. The bone was next partially divided with a small saw, and the section was completed with cutting forceps. The second bicuspid tooth, displaced by the growth, was now extracted, and the body of the bone was cut perpendicularly at this spot by means of the saw and the forceps. After the knife had been passed along both sides of the fragment to divide the mucous membrane and other structures down to the bone, the raspatory and forefingers then completed the operation. Thus the tumour and fragment of bone, stripped of the periosteum, came away in one piece. The facial vessels were not divided, and the bleeding was unimportant, no artery requiring ligature.

Remarks.—Mr. Maunder said such was the usual history of a case of fibrous epulis. It was benign, but recurred unless the bone surface whence it grew was also removed. Further, the growth was generally pedunculated, but in this instance it was sessile. Seven years ago (March 9, 1870) he had, he said, demonstrated in that theatre the feasibility of removing, without external wound, large lateral portions of the lower jaw, the seat of tumour. The patient on that occasion was ten years of age, referred to him by Mr. Owen, of Leatherhead. From that child he had taken away an extent of bone comprised between the middle of the left ramus and the site of the right canine tooth. The second case similarly treated was sent up by Dr. Dove, of Pinner. Both patients have since been often seen in capital health, and he felt justified in stating "that the practice of our art will have one horror less for a patient, who can be assured that no unsightly scar will disfigure his face." He need scarcely suggest that the face of the female should be most scrupulously saved from disfigurement. Neither was it necessary to point out the distinctive characters of the above operation as compared with that of a comparatively trivial kind for the extraction of a sequestrum already nearly accomplished by nature. Fifteen years ago he had seen the late Mr. John Adams remove the whole lower jaw in a state of necrosis; and three years ago he (Mr. Maunder) had taken away in one piece rather more than the body of this bone, necrosed. Both patients were getting new bone generated as a substitute for the original, at the date of operation.—*Lancet*, June 23, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

The Climate of Southern California.—According to a correspondent of the *Boston Medical and Surgical Journal* (Sept. 13, 1877), Southern California, and particularly the Ojai Valley, offers to invalids the following advantages: 1, mildness of temperature; 2, equability of climate; 3, dryness of atmosphere; 4, sheltered situation; 5, freedom from malarious diseases; and 6, plenty to amuse and interest visitors.

Deaths from Chloroform.—In the *Cincinnati Medical News* for August Dr. S. P. Cutter, of Memphis, Tenn., gives the details of the death of Dr. Jourdan, who died while having an eye extirpated under the influence of chloroform.

The *Toledo Medical and Surgical Journal*, August, 1877, reports a death from chloroform in the Homœopathic Hospital of Toledo. The subject was a boy, aged 12, who was undergoing an operation for talipes.

American Dermatological Association.—The first annual meeting of this Society was held at Niagara Falls, September 4, 5, and 6. A number of unusually interesting papers were read and the following officers were elected for the ensuing year. President, James C. White, M.D., of Boston; Vice-Presidents, Drs. C. Heitzmann and L. Duncan Bulkley, of New York; Secretary, R. W. Taylor, M.D., of New York; Treasurer, Dr. J. E. Atkinson, of Baltimore.

The next meeting will be held at Saratoga on the last Tuesday of August.

Endowment of the Chair of Surgery in the University of Pennsylvania.—The widow of the late Dr. J. Rhea Barton, of Philadelphia, has endowed with fifty thousand dollars the chair of surgery in this institution. The professorship will hereafter bear the name of the distinguished surgeon to perpetuate whose memory this liberal gift was made.

Obituary Record.—Died at Ann Arbor, on August 6th, from phthisis, Abram Sager, M.D., late Professor of Obstetrics and Diseases of Women and Children in the Michigan University.

Dr. Sager was born at Bethlehem, New York, in 1810, pursued his medical studies at Albany and New Haven under Professor March and Ives, and graduated in 1835. In 1848 he was appointed to the Chair of Theory and Practice of Medicine in Michigan University, and in 1850 he was transferred to the Chair of Obstetrics. In 1875 he severed his connection with the University on account of the establishment by the regents of chairs for the treating of homœopathy in connection with the medical department of the University. In 1876, Dr. Sager was unanimously elected President of the Michigan State Medical Society—a compliment which was no doubt intended as an indorsement by the profession of his State of the high-minded and exemplary course which he pursued amid those troubles which culminated in the resignation of his professorship.

FOREIGN INTELLIGENCE.

Migraine.—In order to alleviate pain in the course of an attack of migraine, or to cut it short at the commencement, Delioux recommends the juice of a lemon to be squeezed into a cup of coffee without milk or sugar, and drunk off at a draught.—*Med. Times and Gaz.*, Aug. 25, 1877.

The Treatment of Sciatica.—Dr. Flemming gives, in the *Berlin. Klinische Wochenschrift*, the results of his experience of forty cases of sciatica by means of the sand-bath. The patient is placed in a kind of trough, and the affected limb is surrounded by sand, at a temperature of 100° Fahr. or more, for half an hour; after this, a warm-water bath is administered. Recovery is stated to take place, upon the average, after twenty-four sand-baths.—*Lancet*, Sept. 1, 1877.

Effects of Pilocarpin.—Dr. Popow (*St. Petersb. Méd. Woch.*, Aug. 4) reporting upon the results derived from the hypodermic injection of pilocarpin in men in health and suffering from fever, and in experiments upon animals made in Prof. Suschtschinsky's laboratory, comes to the following conclusions: 1. Pilocarpin produces the same effect as an infusion of the leaves of jaborandi; 2. An injection of from 0.01 to 0.02 gramme induces abundant sweating, without causing the unpleasant effects (giddiness, vomiting, cephalalgia) produced by jaborandi, and is, therefore, better suited for therapeutical employment; 3. The temperature diminishes without any prior exaltation, from one hour and a half to four hours, and reaches its minimum soon after the cessation of the sweating; 4. The increased excretion of saliva is observed alike in the healthy and the sick after doses of from 0.001 to 0.015 gramme. Sweating only occurs in such doses in the healthy—fever patients, *e. g.*, typhus, requiring 0.02 gramme; 5. The quickening of the heart's action produced by the pilocarpin continues a pretty long time after small doses, but when large ones are employed this is soon replaced by retardation; 6. On the direct introduction of pilocarpin into the veins a retardation of the heart's action takes place suddenly without any prior acceleration; 7. Doses not exceeding 0.03 gramme do not exert any particular effect on the alimentary canal; but large doses (0.05 to 0.10 gramme) induce purging or even bloody stools, with intestinal movements and the development of gases.—*Med. Times and Gaz.*, Aug. 25, 1877.

Morphia Injections in Puerperal Convulsions —Dr. Dietrich relates (*St. Petersb. Med. Woch.*, July 28) two cases with a view of encouraging the more frequent resort to subcutaneous injection of morphia in puerperal convulsions. In these cases recovery rapidly followed the injection of a quarter or one sixth grain of the hydrochlorate, a repetition being required in one of these.—*Med. Times and Gaz.*, Aug. 25, 1877.

Treatment of Chronic Pharyngeal Catarrh.—Some time ago M. Michel recommended the employment of the galvano-cautery for the treatment of chronic pharyngeal catarrh. The plan has been practised by Riessenfeld in fifty cases, in none of which, however, was there any follicular enlargement. The battery used was that constructed by Middeldorpf, to one electrode of which a knife-shaped instrument was attached, and a series of strokes were made over the tonsils and uvula, the number varying with the severity of the case. The patients bore the operation in all instances exceedingly well, the only inconvenience complained of being the odour of the burnt membrane. Care must always be taken that neither the electrodes nor the conducting wires come into contact with the side of the tongue, lest it should be burnt. The operation is sometimes followed by a little difficulty in swallowing, and the patient should always be directed to gargle the throat frequently for a day or two, and take only fluid nourishment. The eschar becomes detached in the course of four or five days, and the suppuration, if any, rarely lasts more than a week. In the slighter cases a single application of the cautery is sufficient, and even in the worst cases M. Michel has never found it requisite to apply it more than five times.—*Lancet*, Aug. 11, 1877.

Electrolysis in Aneurism of the Arch of the Aorta.—In the *Bulletin de Thérapeutique* for July 15, M. Dujardin-Beaumetz, of the St. Antoine Hospital, relates the first instance in which electro-puncture has been employed for the cure of aneurism of the aorta in France. Bringing his report down to July 10, he says that a certain amount of the blood in the tumour has become coagulated, but the layer of coagulum thus produced is of slight extent. He proposes repeating the applications at intervals of a month, under the somewhat sanguine expectation of producing the eventual complete coagulation of the tumour.—*Med. Times and Gaz.*, Sept. 1, 1877.

Alcohol Dressings in Wounds of the Scalp.—Prof. **Gosselin**, in a recent clinical lecture (*Gaz. des Hôp.*, Aug. 2), called attention to a patient with an extensive contused superficial wound of the scalp, unaccompanied by detachment or denudation. He did so because it was an example of the rapid healing of such wounds which has been so frequently observed under dressing with pure alcohol, without the development of any diffused or erysipelatous inflammation. The rapid cicatrization that takes place is not the result of healing by the first intention, for the edges of the wound still remain a little apart, while the lips and bottom of the wound give issue to sanguinolent seropurulent secretion, in nowise resembling good pus. This secretion gradually ceases, and the wound becomes dry without ever having been covered with granulations. This instance is a good example of the cases which have for some time attracted Prof. Gosselin's attention, in which wounds are healed by this intermediate mechanism, which is neither immediate cicatrization, nor cicatrization after granulation and suppuration. This mode of cicatrization in wounds of the head especially occurs when these are dressed with pure alcohol; other modes of dressing requiring the formation of granulations for healing. Whatever this dressing may be with regard to other parts of the body, in wounds of the head it seems to be that which gives the patient the most protection from consecutive accidents, and leads to the quickest cicatrization. So treated these wounds have less tendency to inflammation and suppuration, are cured quickly, and are less often attended with erysipelas and phlegmonous inflammation.—*Med. Times and Gaz.*, Aug. 18, 1877.

Spina Bifida treated by the Elastic Ligature.— Dr. **Baldassare** relates (*Annali Universali*, May) the case of an infant, eight months old, upon whom he operated for spina bifida situated at the base of the sacrum. The peduncle of the tumour was four centimetres in length. The largest circumference of the tumour measured twenty-two centimetres, its length (including the pedicle) being eleven centimetres. Fluctuation and transparency indicated its contents, and these were not influenced by respiration and only slightly so by compression. The tumour became somewhat more tense in the erect posture. Compression was commenced on the pedicle by elastic ligature on November 30, and by the sixteenth day, the tumour being then in a grangrenous condition with the pedicle reduced to a centimetre in circumference, it was removed by the bistoury, leaving a small depressed space almost filled with granulations. On Jan. 7 the child was well and lively. A linear cicatrix occupied the place of the peduncle, and beneath this could be felt a resisting membrane occupying the place where the bone was defective.—*Med. Times and Gaz.*, Aug. 25, 1877.

Thermo-Cautery in Lithotomy.—Thermo-cautery seems now to be the order of the day in Paris. At a recent meeting of the Société de Chirurgie (*Gaz. des Hôpitaux*, July 21), M. **Verneuil** stated that he had employed it in three cases of lithotomy with advantage. It is used, however, not for effecting the operation itself, but for the performance of its preparatory stage in order to discover the urethra more easily. Its employment, which is extremely easy, facilitates this very much, while it prevents urinary infiltration. Sometimes, however, a fistula persists for a long time, viz., for seven weeks in one of these cases, and three months in another. M. Anger observed that the track caused by the thermo-cautery is a very clean one, and greatly facilitates the penetration of the instruments into the bladder. The incision should be made by rapid strokes, which are to be followed by irrigation with cold water. In his case, although the wound did not cicatrize for thirty days, no urine had escaped after the tenth or twelfth day. The *passage* of urine over the wound, it is true, is not dangerous, but under the ordinary mode of procedure the different planes of the perineum are retracted irregularly, and *stagnation* of urine taking place, infiltration, or at the least maceration, of the wound may occur.—*Med. Times and Gaz.*, July 28, 1877.

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Oiling the Urethra.—M. Desprès (*Gaz. des Hôp.*, Aug. 4) has employed, like all other surgeons, various substances for greasing instruments intended to be passed into the bladder, but has often found, in spite of every precaution, that very painful friction is produced. Although not a partisan for injecting the bladder prior to lithotrity, experience has taught him that greasing the patient is a far more effectual procedure than greasing the instruments. For this purpose he injects, by means of a glass syringe, without any catheter, from seventy to eighty grammes of oil, and thus renders the passage of the instruments far less painful, these passing into the bladder, so to say, by their own weight.—*Med. Times and Gaz.*, Aug. 25, 1877.

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A Ready Method of Clinically estimating Urea in Urine.—Dr. Emerson Reynolds describes a new form of apparatus for the estimation of urea in urine by means of alkaline hypobromite. In his opinion Liebig's method of estimating urea afforded the most accurate results when carefully carried out, but the process is troublesome, and, therefore, unsuited for rough clinical purposes. On the other hand, the hypobromite process (which is but an improved form of the hypochlorite treatment long ago proposed by Dr. Davy) is undoubtedly that which most rapidly affords the desired results, although the latter have no pretensions to a high degree of accuracy. When strongly alkaline hypobromite of sodium is added to urine, pure nitrogen is evolved; this gas is almost wholly derived from the urea, which is known to yield up its nitrogen by this treatment, hence the volume of gas given off approximately measures the urea contained in the given specimen of urine. Various forms of apparatus have been proposed for collecting and measuring the nitrogen, notably those of Russell and West, Blackly, and more recently of Simpson and O'Keeffe, but all these involve the use of specially graduated measuring and other vessels, which are both expensive and not easily obtained. The process which Dr. Reynolds has arranged affords the desired results very rapidly, while the only measuring apparatus required is a common two-drachm minim-measure, which every medical man is supposed to have, and the rest of the apparatus can be fitted up at a very small cost (about 1*s.* 8*d.*), with materials very easily procurable.—*British Med. Journal*, August 11, 1877.

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The Lessons of the London Smallpox Epidemic.—The only uses of such an epidemic of smallpox as that which has raged for the last twelve months are to accumulate fresh evidence of the deadliness of the disease when left purely to nature; in other words, when not modified by vaccination. It is, indeed, pretty clear that no accumulation of evidence will have any effect on those who are not convinced already by the evidence of Marson and others. What is wanting in these cases is not evidence, but intellectual capacity. We say this in full remembrance of the fact that there are one or two gifted men among the enemies of vaccination. Still they have, to put it mildly, a defect or a peculiarity of brain which is not influenced by evidence. Nevertheless we must solemnly record the evidence as it reaches us from those who, in the faithful and painstaking discharge of the loathsome duties of a smallpox hospital, work it out. Though it will not affect the fanatical, it will satisfy those who have complied with the vaccination laws that they have reason on their side; not only so, but that their great security will be in being thoroughly vaccinated—not in a mere formal compliance with the vaccination acts—but in having arms well marked with vaccination scars.

The first instalment of information supplied by this epidemic reaches us from the

Homerton Fever Hospital, in the form of a report from Dr. Collie, the medical superintendent. He gives the result of 915 cases, from Dec. 8th to May 18th. From this it appears that the unvaccinated died at the rate of 53 per cent., the badly vaccinated at the rate of 26 per cent., the fairly well vaccinated at the rate of 2.3 per cent., and that no death occurred in any person under sixteen years of age who showed two good cicatrices of vaccination, and after sixteen only *two such persons died.* Dr. Collie's report is instructive, too, on another point much overlooked—namely, the troublesome and sometimes fatal complications and results of smallpox. We hear much from antivaccinationists of a few pimples that follow vaccination. But what of the things that follow smallpox? In 151 of the 915 cases there were boils; in 18 cases mania followed smallpox, of which 12 proved fatal; in 7 cases the eye was attacked with perforating ulcer, which often leads to blindness; in 24 cases there was inflammation of the windpipe, of which 8 died.—*Lancet*, Sept. 1, 1877.

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Spread of Disease through Laundries.—Though cleanliness is the best safeguard against disease, it is nevertheless an undoubted fact that clean linen is often the medium for propagating smallpox and other similar complaints. Under these circumstances the recklessness and ignorance displayed, not only by common washerwomen, but even by the managers of model laundries, are totally out of keeping with the progress we have achieved in other sanitary matters. The smallest rooms, the most unwholesome back kitchens, still seem good enough for the washing of linen; and the same is dried in passages frequented by the lowest class of persons, and hung between walls on which the dirt of ages has accumulated. The clothes that go nearest to the skin, that are the most likely therefore to introduce through the pores any germs that may fall on them, are thoughtlessly entrusted to a laundress without any inquiry being made as to the suitability of the place where they are to be washed. If they are taken to the suburbs it is simply because rents are cheaper in those districts; but there, as in town, clean and dirty clothes are brought into constant contact, and the washerwoman's family, perhaps also some of her assistants, sleep, eat, sicken, and die, with their customers' linen lying around about them. We have visited innumerable laundries, and what we describe is not the exception but the rule.—*Lancet*, Aug. 18, 1877.

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Deaths from Chloroform.—Two more deaths in consequence of the administration of anæsthetics have occurred during the past week—one at the London Hospital on the 11th inst., and one at the Royal Ophthalmic Hospital, Moorfields, on the 14th inst. That at the London Hospital occurred about midnight. A man applied with an irreducible paraphimosis. After several ineffectual attempts at reduction, which caused the man very great pain, Mr. Hovell, the House-Surgeon, asked one of his colleagues to administer choloroform. A very small quantity was given on a piece of lint. The patient was quickly under its influence. However, in about two minutes, the breathing suddenly ceased, his face became livid, and the pulse failed. Sylvester's method of artificial respiration was at once resorted to, and other measures were adopted, and failed. At the post-mortem examination the heart was found to be flaccid and dilated, and the muscular tissue fatty; it contained a little loose dark clot; there was no valvular disease. No other organic disease. The second death, at Moorfields, befell a woman, aged forty-six; she was extremely fat, and of slow intelligence. She had complained of shortness of breath on exertion, but was not known to be the subject of organic disease. She was to be operated on for senile cataract. A mixture of chloroform and ether, in a modified Clover's apparatus, was being administered by the House-Surgeon. From the commencement of the administration respiration was noticed to be shallow, but there was struggling. The pulse was feeble but not intermittent. There was some slight lividity of cheeks and forehead. Chloroform was at once removed, and a few whiffs of pure ether administered as a stimulant. Other means for restoring circulation were tried, but in vain; the patient died. At the post-mortem examination the heart was found flaccid and empty; the mitral valve was contracted, and the aortic valves were incompetent. Kidneys were fatty and granular.—*Med. Times and Gaz.*, Aug. 18, 1877.

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Death from Chloroform averted by the Inhalation of Nitrite of Amyl.—The *British Medical Journal* (Aug. 18, 1877) publishes, without giving the author's name, the following interesting communication. On the 9th instant, I was asked by a professional friend to administer chloroform to a patient of his, from whom he was about to remove a fatty tumour, situated in the left lumbar region. The patient in question was about forty-nine years of age, married, the mother of several children, of thin, spare habit, but otherwise in good health. She was nervous, and apprehensive of the result, entreating me not to give her too much chloroform. Having previously examined the heart and found all the sounds normal, I gave her about two teaspoonfuls of brandy undiluted; and after waiting a few minutes, and placing her in the recumbent posture, I commenced the administration. The chloroform I used was Duncan and Flockhart's, upon the purity of which we can always depend. I poured a measured drachm upon a piece of lint, enveloped in a towel. I held it some little distance from her mouth and nose, and let her inhale slowly. My friend noted her pulse, whilst I carefully watched the respiration. The first dose did not produce any effect, and I then used another drachm, which soon caused a good deal of excitement, incoherent talking, and struggling—the patient striving several times to snatch the inhaler from my hand. This gradually subsided, and she appeared to be passing into the third stage of anæsthesia, when she made an abortive effort to vomit, raised her head from the pillow, and, to my friend's great alarm, the pulse flickered and stopped altogether; she gave a gasp; foam gathered on her lips; her jaw became rigid; and to all appearance she was dead. I immediately withdrew the chloroform; my friend dashed some cold water on her face and pulled her tongue forward, whilst I commenced artificial respiration, after Marshal Hall's method, but without success. We then poured some nitrite of amyl on lint, and held it to her nostrils. In such emergencies, it is impossible to judge the flight of time correctly; but I should say in ten seconds there was a flushing of the face, the pulse was again felt, and, to our great joy, the all-important function of respiration was again restored; the woman being rescued apparently from the very article of death. After a time, the anæsthesia seeming tolerably profound, my friend proceeded to remove the tumour, which he did in a rapid and skilful manner, whilst, as the patient grew restless, I gave an occasional whiff of chloroform. It proved to be an ordinary fatty tumour. Only one small vessel required to be ligatured. The wound has since healed rapidly, and the patient has made a good recovery. In looking at the order of symptoms, I cannot help forming the opinion that, had it not been for the nitrite of amyl, this poor patient would assuredly have died. I have never seen, either in surgical or obstetrical practice, any one in such imminent peril. I am thankful to say I have never witnessed a case of death from chloroform; but, from the accounts published in the medical journals, both I and my friend inferred that, in the present instance, there was syncope arising from paralysis of the heart, and that this was met by the nitrite of amyl, which, in accordance with its physiological effects, gave a direct fillip to the arrested circulation.

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Fatal Result from Habitual Use of Chloral.—The peril involved in the habitual use of hydrate of chloral has received another illustration. A gentleman, aged apparently about forty, was found dead one morning, at the Nelson Coffee-house, New-cut, Lambeth, where he had lodged for the last three months. The deceased is said to have been an army surgeon, and to have been subject to sleeplessness, to remedy which he resorted to the employment of chloral-hydrate. A verdict of "Death by misadventure" was returned at the inquest held on the body.—*Lancet*, Sept. 1, 1877.

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The Diaphanoscope.—Attempts at lighting up the abdominal cavity for the purpose of diagnosis date from 1860. Milliot in 1867 made an instrument, but only used it on animals and dead bodies. His experiments led Lazarewitch to apply it to gynæcology. He, however, failed to get light without at the same time getting heat, and so burning the patient. Dr. Justus Schramm, of Dresden, has overcome this difficulty, and made an instrument which can be used for any length of time. It consists of two glass tubes, the smaller within the larger, round at one end, at the other fixed to a wooden handle (made, for convenience of cleaning, to screw off). In the inner tube lie two copper wires, connected at one end with a galvanic battery, at the other joined by a slip of platinum. In the outer chamber cold water circulates, to absorb the heat given out by the platinum. In the handle is a button, by which the operator can make and break the current at will. The diaphanoscope is used in a dark room. The patient should be on her back, and her thighs extended. The tube is put into the vagina or rectum; the current is made, and the platinum soon gets white hot, giving a brilliant light. Then a wooden ring is pressed down, and at the same time moved about, so as to stretch and bring near to the light successive parts of the abdominal walls. The contrivance can only be used where the abdominal walls are thin, yielding, and not irritable; and there are many morbid conditions, which we need not specify, in which it is plainly inadmissible. Lazarewitch has described appearances seen with his instrument, which, if confirmed by extended observations, would give it a certain diagnostic value. Dr. Schramm, however, in the few trials he has made with his more perfect apparatus, has failed to get results anything like so satisfactory. But his observations are as yet very few; and it is hoped that further experience with it may lead to something better. Meanwhile we agree with Dr. Schramm's wise remark, that an addition to our resources is always to be greeted with thanks. Although he cannot at present tell us that it is of real use, yet by making known his apparatus he may lead others to experiment with it and improve upon it, and so time may bring practical fruits from it.—*Med. Times and Gaz.*, Aug. 18, 1877.

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The Hôtel Dieu, Paris.—The new Hôtel Dieu was officially opened on the 11th of August by Marshal MacMahon. It appears to have cost forty millions of francs and contains only 400 beds.

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Surgeon-in-Ordinary to the Queen in Scotland.—This position, which was vacated by Mr. Lister's removal to London, has been conferred upon Prof. George Macleod, of Glasgow.

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Astley Cooper Prize.— The prize for 1877 has been awarded to the essay bearing the motto, "Facta non Verba," the sealed envelope accompanying which contained the names of Drs. Eulenburg and Gutmann. The subject selected for the next prize is, "The Cranial Nerves, with reference to their anatomy and its relations to surgical diseases and injuries. The essay to be accompanied by preparations and drawings clearly displaying the course and distribution of the nerves, and especially their mutual connections." Essays in competition, written either in the English language, or, if in a foreign language, accompanied by an English translation, must be sent to Guy's Hospital on or before January 1, 1880, addressed to the physicians and surgeons of Guy's Hospital.—*Lancet*, Aug. 18, 1877.

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CLINICS.

ORIGINAL CLINICAL LECTURES.

Clinical Lecture on Convulsions in Typhoid Fever. Delivered at the Pennsylvania Hospital, Philadelphia. By J. M. Da Costa, M.D., Prof. of Practice of Medicine at the Jefferson Medical College. (Reported by Frank Woodbury, M.D.)

Gentlemen: The rather sudden termination of one of our cases of typhoid fever, towards the close of its third week, makes it incumbent on me this morning to explain to you the mode of death, and to point out to you some uncommon features of the speedy and unexpected end. Just as convalescence appeared definitely established and the patient seemed out of danger, he was seized with general convulsions, and in a few moments expired.

After refreshing your recollection of the case by reading the clinical notes, I propose to devote the remaining portion of the hour to discussing the significance of convulsion as a symptom in typhoid fever, and its bearing upon the treatment of the disease:—

Albert McD., a seaman before the mast, was brought, Dec. 30th, 1876, from shipboard into our wards, with the statement that he had been sick for two weeks, the principal symptoms being great prostration, fever, headache, and diarrhœa. The remainder of the crew were healthy, and no cause was assigned for his illness.

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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He was 21 years of age, unmarried, of good physical frame, and, to all appearance, a man of temperate habits.

His axillary temperature on the evening of admission was 104°. During the night he was delirious, but the next morning he responded intelligently to questions, and gave a connected account of his illness. He stated that he had been suffering with diarrhœa for a week before, being regarded as unfit for work, and that he had been in his berth for only ten days before admission, during which time he was pursued by strange dreams. The headache was principally frontal, and was severe and constant. The record taken on his admission into the hospital, speaks of his tongue being dry and coated from the centre to the edge, and displaying a red wedge shaped patch, its base corresponding with the tip of the tongue. The gums and teeth were covered with sordes, and the breath was offensive. There was complete loss of appetite; the bowels were moved twelve or fifteen times a day, the discharges being watery. The abdomen was tympanitic, and a few rose-coloured spots were seen on the lower part of the chest and abdomen.

The kidneys performed their function well, and the secretion was of a light amber colour, acid in its reaction, of specific gravity 1020, and contained a small amount of albumen; a microscopical examination failed to discover casts.

He was ordered dilute nitro-muriatic acid, ten minims thrice daily, and eight grains of quinia daily. To relieve the diarrhœa, he received suppositories of acetate of lead and opium. During the next few days he gained rapidly, and the temperature-chart showed the declining gradations peculiar to this stage of the disease; thus his temperature on

Dec. 30 was		104° P. M.
Dec. 31	102½° A. M.	103½° P. M.
Jan. 1	102½° A. M.	103° P. M.
Jan. 2	101½° A. M.	102° P. M.
Jan. 3	101½° A. M.	100° P. M.

Jan. 4th the temperature in the morning was 101°, and the patient had a pulse of 96, of good volume, an only slightly heightened respiration, and no cerebral symptoms; yet he died in the afternoon after a convulsion lasting a few moments. During its progress the face became purple, the head was drawn back, the neck swelled; he seemed to be gasping for breath, and struggled so violently that his limbs had to be held by the surrounding patients to prevent his being thrown from the bed.

Passing by the minor details of the case, we notice, first, that the statement of the patient, that he had been ill for nearly three weeks, was confirmed by the temperature observations. The highest point marked was 104°, on the evening of admission; following this, the evening exacerbations, after each morning's fall, showed a declining series. Nor was the improvement to be found only in the vanishing fever heat; there was no fresh eruption of rose-coloured spots, indeed, those noticed upon admission were gradually fading, the discharges were reduced and under control, the tongue was cleaning, and he slept at night without delirium, when, without warning or apparent cause, we notice that he had a violent, general, and rapidly fatal convulsion.

Now let us see if the autopsy explains this unlooked-for result, or is able to throw any light upon the cause of death. In cases of sudden termination of typhoid fever, we naturally think of intestinal perforation, of exhausting internal hemorrhage, or of cerebral effusion; in the present case this is not a subject merely of speculation, as we have the organs before us; and it is to their appearance that I invite your attention.

Autopsy.—The lungs, with the exception of some engorgement posteriorly from hypostatic congestion, are found to be healthy and crepitating throughout. There is no evidence of pleurisy; there are no adhesions or effusion. The *heart* weighs 10½ ounces; the left side is firmly contracted, the ventricle being empty, the auricle full of fluid blood. The right side seems flabby, the ventricle containing some fluid blood and a white, fibrinous clot, the auricle having fluid contents and no clot. The cavities, walls, except as regards the flabbiness of the right side, and the valves appear healthy.

The *stomach* shows some congestion of mucous membrane, and holds coagulated milk; the membrane is reddened, and is softer than normal.

The *peritoneum* contains some serous fluid, but exhibits no other sign of disease.

The *liver* is healthy in every respect.

The *spleen* is large and flabby; it weighs 19 ounces, and in section displays a currant-jelly appearance; the tissue breaks readily under pressure.

The *mesenteric glands* generally are enlarged.

In the *small intestine* there is no evidence of ulceration or perforation, but there is marked increase in size in *Peyer's patches*, and in the *solitary glands* of the large and small intestines. These look like shot under the mucous membrane; Peyer's patches are very much infiltrated, and darker in colour than the surrounding parts. There is nowhere a sign of perforation.

The *kidneys* weigh 7 ounces each. The left is large, firm, and irregular. The capsule is thickened, adherent, and on removal leaves a markedly granular surface. Upon section, a urinous odour is noticed, the organ is congested, especially in the pyramids, and the cortex appears slightly swollen. A similar condition is found in the right kidney. The pathologist has just given me a report of the microscopic examination of the kidneys in this case, in which he pronounces them to be in a state of granular degeneration.

The *supra-renal capsules* are normal.

The *brain* is rather soft, but is perfectly natural on gross examination.

Now, looking at the post-mortem results, we find in the kidneys alone sufficient ground for the explanation of the convulsive seizure; and its uræmic nature is further rendered most probable by the presence of albumen in the urine, and by the well-known fact of the favouring element of the accumulation in the blood of the products of waste and disintegration of tissue during the fever process. But before we adopt this view, let us consider what other causes may determine convulsions in typhoid fever; and thus see whether any of them is likely to have been at work in this particular case.

A patient may have a convulsion from overloading the stomach. Every hospital physician knows that the friends of the sick man have ways of eluding the most Cerberus-like of gate keepers, and are thoroughly happy if they can convey quantities of apples and peanuts to the patient to fill his stomach with when the attention of the nurse is diverted. The smuggled articles may have all the proverbial flavour of forbidden fruit, but they often lead to disastrous consequences. Among these may be convulsions, and death may occur as the direct result of paralysis of a heart already weakened by fever. We have a parallel in the way feeble children perish from convulsions brought on by indigestion. In the case we are discussing there was some suspicion of improper food having been given, but at the autopsy none was found in the stomach.

Now as to the direct influence of the typhoid fever poison itself. Could the nervous system be so excited by this as to produce a convulsion? In answering this question you will naturally think that the nervous symptoms are among the most prominent in typical cases of typhoid fever; you will recall the irregular chills at the onset of the disease, the pains in the loins and limbs, the ringing noises in the ears, the giddiness, the severe headache, and the profound prostration; you will reflect on the restlessness, subsultus, vigilance, and delirium which belong to the course of the complaint almost as surely as do the diarrhœa and fever; you will think of all these evidences of great derangement of the nervous system, and be prone to conclude that convulsions are likely to be among them. But they are not. Convulsions in typhoid fever are rare, so rare as to be regarded almost as a clinical curiosity, and to be set down as something outside of the regular history of the disease. In nearly three thousand cases of enteric fever admitted into the Fever Hospital in eight years convulsions occurred in only six, Murchison tells us in his classical treatise. In typhus they happen much more frequently.

When I make these statements I allude

to general convulsions. Spasmodic movements, such as jerking of the tendons, hiccough, twitchings of the muscles of the face, are, we know, not uncommon in typhoid fever; and choreic movements, rigid contraction of the muscles of the extremities and even cataleptic states, though far from common, have been often described. But convulsions from any cause in typhoid fever are extremely infrequent; and the most unusual kind is from the direct influence of the poison on the nerve centres. At least this is true of adults: a different statement must be made of children. But whether in children or in adults, convulsions due to the fever poison alone, happen at the onset, or in the first week of the malady.

Gentlemen, you know well that the vagaries of hysteria baffle any description. Among these vagaries is the occurrence of hysterical seizures in the early part of typhoid fever. I saw such a case a few years since with an eminent physician in this city. The hysterical outbreaks and convulsions in the first week of the fever were extraordinary and misleading; violent neuralgic pains in the head also existed, and the case looked like anything else rather than like one of typhoid fever. Nothing but the decided fever temperature and a certain irritability of the bowels excited even suspicion. On the eighth day appeared the characteristic eruption. I am sorry to add that the case became a very grave one, and died in the second week.

Epilepsy is among the causes of convulsions during an attack of typhoid fever. The wonder is that it does not show itself oftener. The reason I suppose to be in the strange law by which the affection is temporarily obliterated when an epileptic is stricken with an acute disease. We see whooping-cough suspending it, fevers lulling it. But the malady is not dead, it is slumbering; and it may start up vigorously during the last stages of the fever or during convalescence. I attended a case some time ago, in which three epileptic seizures happened in the course of twenty-four hours in the third week of the enteric fever. There had been no kidney complication, and no cause other than epilepsy could be discovered for the attack. The patient was very drowsy after it, yet the recovery was not much retarded by the accident. A positive diagnosis in such cases can only be made by the aid of inquiry concerning the previous history. But the time of the occurrence of the convulsions should always arouse our suspicions.

Typhoid fever may become complicated in its course with apoplexy, and the effused blood lead to such damages as to give rise to long-continued palsy. A case of this kind, with right-sided hemiplegia of two years' standing, came under my notice recently at the clinic of the Jefferson Medical College, in the person of a sturdy young farmer. Where the clot is effused on the surface of the brain, convulsions may readily be associated with the apoplectic seizure.

There are a few other causes of convulsions in typhoid fever that I will mention to you, though they but very rarely happen. If in a child, pneumonia of the apex of either lung should complicate the fever, convulsions may be met with. Clogging of the vessels, either those supplying the brain or elsewhere, may be attended with convulsions.

Syncope, combined with anæmia of the brain from the defective circulation, may happen during convalescence, but cannot readily be confounded with convulsions. Nor need it excite alarm, unless during the interruption to the circulation a clot should form in the heart and pulmonary artery, in which case there will be gasping and struggling for breath, the face becoming cyanotic; in this condition death may ensue in the course of a few moments. Convulsions, then, should not be anticipated from pure anæmia of the brain, except indirectly, by disturbing the heart's action so as to lead to the formation of thrombi. But as the result of thrombosis, and especially of a clot extending into the pulmonary artery, they certainly happen. Murchison records an instance of convulsion, with thrombosis of the left femoral vein.

Might convulsions be due to remedial agents given in the treatment of the disease, such as large doses of quinia? This is, I think, possible; for, as you are fully aware, cinchonism is announced by its influence on the nervous system, especially on the cerebral nerves, and one of the toxic effects of the drug, proved by physiological experiment, is general convulsions. I merely refer to this as among the possible exciting causes, although I have never met with an instance of the kind. Yet it is well to bear the possibility in mind. It has become, lately, a prevailing treatment, imported from Germany, to give enormous doses of quinia to reduce the temperature—as if typhoid fever consisted merely in heightened heat of body! Let us hope that no accidents will attend this therapeutic doctrine.

The causes that I have alluded to may all lead to convulsions in typhoid fever. But it is, after all, in connection with the disordered condition of the urinary function that we mostly find this symptom. I told you, at the beginning of the lecture, that I believed uræmia to have determined, in the case we have been investigating, the fatal convulsion. Irrespective of the diseased appearance of the kidneys which I have submitted to your inspection, you may judge, from the description I have given you of other exciting causes and how they act, that they do not here apply. Let us now study a little more closely how the uræmia with its dire results is brought about.

The noxious urinary ingredients may be absorbed into the blood in consequence of the distension of the bladder. It is well known what a paralyzing effect low fever exerts on the muscular coat of the bladder. The viscus may become greatly distended, as we can recognize by percussion, although the patient seems to be voiding natural amounts of urine. The result of the accumulation may be the poisoning of the system with urea or the products of its decomposition. I shall not readily forget the impression made on my mind by a case of this kind seen a number of years ago. The young man lay for several days in a state of semicoma, associated with marked twitchings of the muscles of the face. He was more than once on the verge of a general convulsion; passing a catheter several times a day after the difficulty was recognized, removed the untoward symptoms.

But the most common cause of the uræmic poisoning, and of the convulsions that may attend it, is to be found in disorder of the kidneys. If, indeed, you will collect the recorded cases—they are, it is true, not many—you will find a condition of diseased kidney or antecedent albuminuria in the majority of them, although the connection between this and the convulsion may have passed unnoticed. But is albuminuria always antecedent? Not to needlessly obscure the subject in your minds, but to warn you of a source of fallacy, I must state that, in some cases of fever, there may be an excess of urea and the products of tissue-waste in the blood, progressing even to the production of uræmic convulsions, without the presence of albumen in the urine. The secretion in this case is scanty. The urea is found in deficient quantity in the urine; while in the blood we find alterations produced by its presence, or of the substances it gives rise to. We may have to seek the advice of the professional chemist to determine this point; and I have more than once been most efficiently aided in solving the obscure clinical problem by the skill of our pathological chemist, Dr. Hare. Again, convulsions, at any time and from any cause, may themselves produce transient albuminuria, so that the detection of albumen in the urine for a day or two after the attack is not sufficient to establish its uræmic character.

In cases where albuminuria and undoubted disease of the kidney exist, and convulsions have happened, does the renal difficulty antedate the fever, or, is it a complication? It may be either. Chronic nephritis grants no immunity from typhoid fever; on the other hand, an engorgement of the kidney, an accumulation of epithelium in the tubules, and the beginning of a parenchymatous nephritis are met with, as part of the typhoid fever process, and may be sufficient to clog the kidney to such an extent as to interfere with its function. You will ask me how are we to know if the kidney disorder belongs to the fever or not? We cannot always know.

It is true that considerable quantities of albumen, the presence of markedly granular or fatty casts would determine the antecedent nature of the malady. But some tube casts may also be found in the urine coming from the hyperæmic fever kidneys; and we may not detect them at one examination in the urine of a chronic renal affection. The presence of albumen from the onset of the fever would greatly favour the supposition of the latter; for in typhoid fever albuminuria is not an early symptom. Again, we may have the lesions determined by the fever process adding to the embarrassment of an already diseased organ; and thus producing the inaction which has led to the uræmic seizure. Such I take it happened in the case which we have been discussing this morning.

Now, I have conveyed to you a wrong impression if I have led you to suppose that convulsions must always happen in consequence of the uræmia met with in fevers. Coma is, perhaps, the more common result; or a state of half-coma with convulsive twitchings. We have recently had a case of uræmic coma in the hospital which some of you have seen, and you will pardon the slight digression from my subject if I tell you here of its progress, and call your attention to the pathological specimens:—

Alex. N. V., a sailor, 21 years of age, born in Finland, was brought into the ward a few days since, having been seriously ill for two days. Diarrhœa had previously existed, but had been checked by medicine received from the captain of the vessel. As the patient could not speak English, only an imperfect account was obtained of his illness, but from the statements of his shipmates it was thought that he had been sick altogether for nearly three weeks, although not confined to bed until a few days preceding admission. His chief symptoms had been prostration, profuse diarrhœa, headache, fever, and nocturnal delirium. Upon entering the hospital in the morning his temperature in the axilla was 103° which declined to 101½ in the evening; his face was dusky, though the cheeks were flushed, and the eyes bright; but his mind was dull, and he responded to questions reluctantly. The tongue was coated and fissured, having a decidedly typhoid appearance, the gums were covered with sordes. The abdomen and chest were examined for rose-coloured spots, but none were detected; considerable tympanitic distension was noticed with gurgling on pressure over the ileo-cæcal valves. The urine was decidedly albuminous, although not to a highly-marked degree; it is to be regretted that there is no exact note of its microscopical appearances. On the night succeeding admission he was delirious and noisy, and the bowels were very loose, the discharges having the usual typhoid appearance.

The treatment instituted was by frequent small doses of mineral acids, eight grains of quinia daily, with milk punch and beef tea. Opium suppositories were given occasionally to reduce the discharges, and the body was sponged with tepid water three times a day. As a result of this the temperature, which had indicated 103½° on the second morning, did not rise above 103° in the evening, and the patient appeared better. On the next, or third morning, the temperature had fallen to 101½°, yet an unfavourable change was noticed. During the night he had been delirious as usual, but when seen, early in the day, he was found in a condition of profound hebetude. His face was flushed, the eyes were injected and motionless, his breathing was laboured and stertorous, and only with the greatest difficulty could he be aroused from this almost senseless condition to give any sign of recognition or to take nourishment, and, when aroused, he immediately relapsed into this semi-comatose state. He had passed but little urine, yet the bladder was not distended. The breathing was rapid and embarrassed.

His feeble condition forbade extended physical examination. It was determined, however, that slight dulness existed at the base of the right lung, and that on the left side exaggerated and harsh respiration existed. The first sound of the heart was feeble, the second was distinct; the pulse had risen from 100 to 120, and was very compressible. In view of his sinking condition, the quinia was increased to twelve grains, and tincture of digitalis was ordered to be given in ten minim doses every four hours. The acid was discontinued. Stimulants were freely administered, and his chest was thoroughly dry-cupped, but the stupor deepened, the difficulty of breathing increased, and he died in the afternoon in an unconscious condition, with every evidence of profound coma.

Not to dwell minutely upon the details of the post-mortem examination, it may be stated that nothing notable was found in the *lungs* except spots of congestion, especially on the right side, and no effusion was discovered in any of the serous cavities. In the *heart*, which in size and general appearance was normal, a white, fibrinous clot existed in the right auricle and ventricle, extending into the pulmonary artery. The left ventricle was empty, the auricle contained a recent dark coagulum. The *spleen* was congested, large, and heavy, weighing 13½ ounces. The *liver* was also large, but appeared to be normal.

The glands of the small *intestine* and the patches of Peyer were swollen and contained hemorrhagic points of minute extravasation. The solitary glands in the colon were not enlarged. The mesenteric lymphatics were prominent and engorged, but not softened. On section they displayed a pinkish surface.

The *kidneys* were found to be in a decided state of disease, although not in an advanced stage. The left was the larger, its capsule was firmly adherent; the cortex was opaque, whitish, and the stellate veins were distinct. The cut section had a urinous odour, the parenchyma was congested, the pyramids being more red than the cortex, which was swollen and appeared relatively increased in size. This organ weighed seven ounces. The right kidney presented the same general characters, but weighed one ounce less. The weight of the normal kidney in this patient, taken in proportion to the size of the other organs, should be about five ounces, or not more than five and one-half. The whole appearance of the organ affords an illustration of the large kidney of acute tubal nephritis, or parenchymatous inflammation.

This case tells its own story. I will do no more than call your attention to the marked evidence of disease of the kidneys, which seems to me to have been acute and an outcome of the fever process, and to the heart, or rather to the clots in it. Some doubt must exist as to the time of their formation. The one extending from the right ventricle had the look of being an ante-mortem coagulation; and it seems to me quite possible that some of the phenomena of the case, the pulmonary signs in particular, were due to a forming thrombosis in the pulmonary artery.

But I must revert to the subject I have been attempting to elucidate, convulsion in typhoid fever. We have found that it may be due to a variety of causes, though uræmia is the most prominent. The *prognosis* will of course depend very much on its exciting cause. It is generally unfavourable. The most favourable prognosis is, if the seizure be in an epileptic and an outbreak of epilepsy, or if the subject of the convulsion be a child overcome at the outset with the fever poison, or be affected with an apex pneumonia; of the uræmic convulsion, that associated with retained urine in a distended bladder justifies the most hope.

The *treatment*, too, will largely depend on our knowledge of the cause. I will merely point out how important it is to take care that the broken-down waste is not retained in the body, and that the kidneys are kept freely acting; and how readily careful attention to the state of the bladder may prevent a serious mishap. During or soon after the fit we must see to it that the head is kept cool, and the flow of blood in the body equalized. Cupping at the back of the neck, and even general bloodletting, suggest themselves among the remedies to diminish the vascular tension. These remedies are potent also for evil; and it must in an individual case always remain a matter for judgment, whether the patient is in greater danger from a local injury to brain or lung and the general turgescence of the vessels, or from the extreme debility that attends the fever. In deciding this the pulse and the state of the first sound of the heart are our chief guides. But I cannot now further enter into this subject; it involves much, having a wider range than can be accorded to my discourse. Let me only add that, if the convulsion be due to apoplexy, and associated with one-sided palsy, the abstraction of blood seems to me imperatively indicated. If the convulsions are epileptiform in a subject predisposed to epilepsy, bromide of potassium will be our main reliance. But, whatever treatment be employed, let it be active, and take into account the pathological condition which has occasioned the outburst.

HOSPITAL NOTES AND GLEANINGS.

Two Cases in Illustration of the Efficacy of Chrysophanic Acid in the Treatment of Psoriasis, after failure of various other Remedies. — The following cases were treated by Dr. Whipham at St. George's Hospital.

Case 1.—E. F. S., aged seven, was admitted into St. George's Hospital, under my care, on March 21, suffering from a copious eruption of psoriasis. His mother was a person of strumous habit. Of six brothers and sisters, one died in infancy; one, at ten months old, had an abscess on the cheek; the others are very healthy. The boy himself was brought up by hand. Had measles when three years old; no other disease. He was always pale and delicate, with a bad appetite, and subject to vomiting after food; occasionally he suffered from headache. Has always lived well. He had never suffered from cough or glandular swellings; there is no history or appearance of hereditary syphilis. Has always been "nervous," and is less intelligent than his brothers and sisters. The present eruption of psoriasis began with one spot on the back in September, 1876; a month later it appeared on the legs. His general health has not been in any way affected.

On admission there were numerous patches or psoriasis, with thick masses of scales, and varying in size from that of a threepenny-piece to that of half-a-crown, upon the legs, arms, and trunk; one small one on the left upper eyelid. The patient is well nourished, but of markedly strumous appearance. General health good; no cough; tongue red, with prominent papillæ; bowels open. Ordered—Ol. morrhuæ ʒjss, syr. ferri iodid. ʒss, bis die. Picis Burgund., sapon. moll., sp. methyll., part æqual; to be rubbed into the affected skin. Pulv. rhei c. sod. gr. v om. nocte.

March 27. The scaliness has disappeared, and the subjacent thickening of the skin has diminished; while at the same time the redness of the patches has markedly subsided. The bowels have been confined for the last day or two, but are well open to-day; tongue as before.

29*th*. The pitch ointment to be applied to the left leg, and to the right the ointment of nitrate of mercury.

31*st*. The condition of the right leg is much improved, whereas the patches on the left are very little altered. Ordered—Liq. potassæ ♏vj, haust. cinchonæ ℥j, ter die. Pulv. rhei c. sod. ℈ss omni altern. nocte. The nitrate of mercury ointment to be used solely.

April 10. Both legs are improved as regards scaliness, but there is no appearance of healthy skin in the centres of the larger of the affected parts, although the smaller spots are gradually fading.

12*th*. A drachm of cod-liver oil to be given with each dose of the medicine, and a soda bath every night.

Little or no improvement was observed up to April 28, when the following ointment was ordered to be applied to the eruption: Acid. chrysophanici ʒss, adip. ℥j.

On the eighth day after this application the eruption had almost disappeared; one or two minute spots only remained on the legs where the ointment had been too sparingly applied; these disappeared in the course of a few days. The patient suffered from incontinence of urine, and as the prepuce was very long, it was removed, and he remained in hospital under the supervision of the surgeon for a few weeks. The chrysophanic acid ointment was discontinued on May 11, and he was kept under observation until June 29, up to which time no recurrence of the disease had taken place. A few hours subsequently to the application of the ointment the unaffected skin became of a purple-red colour, which disappeared on pressure, while the sites of the patches of psoriasis, after the thickening had subsided, remained perfectly white. This dusky red colour speedily faded after the ointment was discontinued, and the skin generally, including that of the diseased parts, assumed a natural appearance.

Case 2.—In the spring of the year 1874, Selina W., aged fifteen, a domestic servant, living in the country, came under my care as an out-patient in the department for diseases of the skin at St. George's Hospital. She had then a copious eruption of psoriasis over the trunk, arms, and legs. The eruption had commenced two years previously, and, with partial remissions at different times, had been steadily on the increase, this increase being more especially marked in the spring.

She was a remarkably well-grown girl, and looked six or seven years older than her stated age; she was, moreover, in robust health, her only complaint being profuse and occasionally deferred catamenial periods. She, however, never exceeded six weeks.

Her family history was good, her parents lived in the country, and there was no account of syphilis either hereditary or acquired. The appearance of the eruption and the catamenia were contemporaneous, but, beyond the slight irregularity of the latter above mentioned, the girl was in perfect health.

The treatment consisted in careful attention to her diet; beer, which she had been in the habit of drinking in moderate quantity, was discontinued, and her food was to be of the plainest description. She was ordered—Liq. arsenical. ♏iij, dec. cinchon. ℥jss, ter die. At first the treatment seemed to be productive of good results, more especially as regards the trunk, but eventually lost its effect as the autumn came on. No alteration was, however, made in the treatment until February 11 in the following year, when nitrate of mercury ointment was ordered to be rubbed into the affected parts.

On May 6, 1875, as the eruption was rapidly increasing, the treatment was altered with a view of increasing the action of the kidneys, and the following prescription was ordered: Sp. æther. nitros. ʒj, tinct. scillæ ♏x, potass. acetat. ℈ss, h. acet. ammon. ℥jss, t.d.s. Rep. unguent. hydrarg. nitrat.

This change produced speedy results, and on July 27 the note runs: "Only one or two patches on the arms, but there is an increasing tendency to the formation of fresh spots, which, however, soon fade." It appeared that the disease was again on the increase.

On August 26 she was much better.

On October 21 the eruption had not improved, and it was deemed advisable to try a mixture containing tincture of rhubarb and bicarbonate of soda in infusion of cloves.

She continued stomachics, etc., with little or no benefit until January 20, 1876, when her treatment was again altered as follows: Liq. hydrarg. et arseni. hydriodat. (Donovan's) ♏viij, inf. gent. co. ℥j, ter die; and upon this she again improved for a time, but in about six weeks the improvement ceased, and the eruption again began to spread. The medicine was continued for some months, until finally the gums showed decided evidence of mercurial poisoning, and all medicine was discontinued for a time. Before this the patient had ceased to attend the hospital, owing to a regulation of the Board limiting the period of attendance for out-patients.

At the beginning of March, 1877, I saw her again, and found that the psoriasis had recurred in all the original situations, and that she was as bad as when she first came under observation. I then ordered her to take three times a day a pill containing one-twentieth of a grain of phosphorus.

On April 1, I found that the psoriasis was rapidly disappearing. The improvement, however, was of very short duration; and on May 31, 1877, the eruption was rapidly extending on the limbs and trunk. I prescribed for her an ointment: Acid. chrysophanici gr. l, adipis præp. ℥j, to be rubbed well into the patches night and morning. At the end of a week I heard that the unaffected skin was "of the colour of a red Indian," and that she had a running at the eyes and slight dimness of sight. I therefore directed the ointment to be applied every other night.

On June 21, exactly three weeks after the commencement of chrysophanic acid ointment, I saw my patient, and found that, with the exception of one or two scaly unthickened spots (each rather less than the size of a pea, on each wrist), she was quite free from all trace of the skin disease. Her skin at the time of this visit was of a dull purple colour, such as one sees when the face of a person with a florid complexion is sunburnt. Her health was excellent, and the catamenia were quite natural, both in time and amount. She was directed to apply the ointment to the spots on the wrists once a day.

On July 22 I again saw her, and found all traces of the eruption gone, and her skin natural. She had discontinued the ointment some weeks.

Remarks.—Of the two cases, the second is a most striking example of the remarkable effects of chrysophanic acid in the cure of psoriasis. I have briefly alluded to it in the *St. George's Hospital Reports*, vol. viii. page 227, and the statement therein, that the disease had baffled all my attempts at cure, must now be considerably modified. The "Notes from the Skin Clinique" were written many months before the publication of the volume, and at that time no remedy had produced any permanently good effects in my patients. In a footnote on page 227 of the *Reports*, mention is made of the fact that the psoriasis was disappearing under the use of phosphorus, which was commenced in March, 1877. By the end of May, however, the disease was nearly as bad as ever, and it was evident that the drug was of no use in relieving her ailment. After so many and repeated failures (the majority of which have been mentioned in the necessarily curtailed notes of a case which had been under treatment for more than three years), it was not without a feeling of despair that I had recourse to chrysophanic acid; the result, however, and the rapidity with which that result was brought about, surprised me extremely—a surprise which is not lessened by the recollection that the girl had suffered from the skin disease for five years and a quarter at the time when the acid was first employed, and that she was entirely free from psoriasis in twenty-one days. Possibly the psoriasis might have yielded to local applications of pitch, etc., but, as I have mentioned in the *Hospital Reports*, I had no opportunity of trying it, owing to the inveterate dislike of her mistress to the smell of such preparations. The case of the boy also illustrates the beneficial effect of the drug, though to a less degree. I have here placed the two cases together, because they *appear* to me to show that chrysophanic acid has some distinct action in certain forms of skin disease independently of the patient's diathesis. The subjects of the above notes differed in almost every respect. The boy was pallid, of small stature, and very delicate in appearance; he was, in fact, as stated by Dr. Owen (Medical Registrar at St. George's, to whom I am indebted for the notes of the case), essentially a strumous child. Selina W., on the other hand, was a remarkably well-proportioned country girl with a florid complexion, who, with the exception of a trifling catamenial irregularity when she first came under notice, was in most robust health. In the case of the boy the eruption had disappeared eight days after the employment of the chrysophanic acid, and so far this case contrasts favourably with that of the girl S. W. It must, however, be borne in mind that the scaliness of his disease had been greatly modified, if not entirely removed, by previous applications, while to hers no local treatment had been employed for a long time. In the case of S. W., certain irritating effects resulted from the use of the drug. Redness of the skin is a usual sequela of its local application, but this redness in the majority of cases seems to be limited to the neighbourhood of the affected parts to which the acid has been applied. In the present instance the effects were more extensive; the face generally became swollen (it must be noted that the eruption did not involve the head or neck, and consequently the ointment was not used above the shoulders). Dimness of sight was also mentioned by the patient as one of the effects of the remedy, but on questioning her I was inclined to attribute this symptom rather to the "running at the eyes" than to any interference with the function of the eye itself, more especially as she recovered her natural powers of sight within a few hours of discontinuing the use of the acid. Failures will, doubtless, occur with this, as with all other remedies, which at first appear to be productive of such extraordinary results. At present our knowledge of the action of the drug is limited, and recorded cases are few in number. It is with a view of adding to these records that the above cases are published.—*Med. Times and Gaz.*, Sept. 22, 1877.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Original Clinical Lectures.—With this number we begin the publication of a series of clinical lectures specially reported for the Medical News. We are induced to make this change in the belief that original American clinical lectures will be more attractive to our readers by furnishing a narrative of diseases as they appear among us, with the modifications which may be produced by surrounding conditions, and of their treatment as defined by our leading medical teachers.

The extremely interesting lecture which we present in this number was delivered by Dr. Da Costa, and, very appropriately to begin our series, in that venerable institution, the Pennsylvania Hospital, where clinical lectures were first given on this continent. Succeeding numbers will contain lectures by Drs. Weir Mitchell, Gross, Flint, Sayre, Pepper, Bartholow, Hutchinson, and other prominent clinical teachers in various sections of the country. With such names, and with the vast amount of interesting clinical material at command in all our cities, it is needless to state that our standard of merit will be as high as when our lectures were selected from the best of those published in foreign journals.

Deductions from some Mortuary Statistics.—Dr. E. Fletcher Ingals, in the *Chicago Medical Journal* for October, 1877, presents a study of the mortuary statistics of the principal cities of the Union, and deduces the following conclusions, which, although he does not claim to be established facts, he thinks bear the stamp of strong possibilities.

1st. Residence by the sea-shore is prejudicial to phthisical patients.

2d. There is something peculiar to the climate of San Francisco, or to the business and social relations of its inhabitants, which strongly predisposes to aneurisms.

3d. A large percentage of the mortality in Chicago is the direct result of organic poisons emanating from the slaughter-houses, glue factories, and rendering establishments of Bridgeport, and the foul water in the North Branch.

University of Pennsylvania.—It augurs well for the future of medical education that the profession has unmistakably shown its sympathy with those schools which have honestly endeavoured to raise the standard. The last effort, that of the University of Pennsylvania, an outline of which we traced in our June number, has met with a cordial response. Contrary to the expectations of the University authorities, the class has not undergone any temporary reduction, and about 140 new students have matriculated for the three years' course.

We are glad to learn, that, since the changes in the curriculum have been made, the Chair of Surgery has been endowed with fifty thousand dollars; and that the guarantee fund, of about seventy thousand dollars, which was raised to protect the school against the supposed loss of income consequent upon the expected reduction in size of the class, being not needed for this purpose, will be passed over to the general endowment fund of the Medical Department.

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Catalogue of the Alumni of the Medical Department of the University of Pennsylvania.—The Society of the Alumni of the Medical Department have just issued a handsome catalogue of the medical graduates of the University. It is an octavo pamphlet of 206 pages, and contains the names of about nine thousand graduates. We trust that the work will meet with such a ready sale as to warrant the Society in issuing a revised edition every ten years.

In the preface we find it stated that no general catalogue of medical graduates has been published since 1835. This we suppose is a misprint, as it is certainly an error. The last general catalogue, we believe, was published in 1845, and in the third edition of this there are included lists of the graduates of 1845 and of 1846.

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Warren Triennial Prize.—We are pleased to learn that this prize, which amounts to nearly four hundred dollars, has been awarded to Dr. E. O. Shakespeare, of Philadelphia, for his essay "On the healing of Arteries after Ligation." The number of competitors is stated to have been exceedingly large, and several of the essays reflected great credit upon the industry and ability of the writers.

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American Journal of Obstetrics.—The October number completes the tenth volume of our valuable contemporary, and we are glad to learn that the increase of its circulation has induced its publishers to add 48 pages to each number without increase of price.

—

Lectures on Artistic Anatomy.—Dr. W. W. Keen will deliver a course of lectures on Artistic Anatomy at the Pennsylvania Academy of the Fine Arts, corner Broad and Cherry Streets, Phila., beginning on Saturday evening, Nov. 3, 1877. The course will consist of about thirty lectures, and will be illustrated by diagrams, casts, anatomical models and preparations, and the living model. The proceeds are for the endowment of the library.

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Remedy for Burns and Scalds.—Dr. G. F. Waters, of Boston, recommends the use of bicarbonate of soda as a local application to burns and scalds. The soda must be sprinkled over the injured part, and a wet cloth applied over it. Under this treatment the pain is almost immediately relieved, and the healing process goes on very rapidly.—*Med. Record,* Oct. 20, 1877.

FOREIGN INTELLIGENCE.

An Epidemic of Typhoid Fever spread by the Milkman.—A short time ago Dr. Littlejohn, Medical Officer of Health for Edinburgh, received information of a serious outbreak of typhoid fever at Coltbridge and other districts in the west end of the city, which it was believed had been caused by means of milk sold at a dairy in which a person was suffering from the fever. The district in which the outbreak first occurred is beyond the municipal boundaries, but Dr. Littlejohn lost no time in moving in the matter, the patient being removed to the infirmary. At the same time he communicated with the sanitary inspector for the district, with a view to steps being taken to have the surroundings of the dairy in question improved. The retailers of milk in Edinburgh who received their supplies from this dairy have been advised to discontinue their orders for the present, and this recommendation has been acted on. At present over twenty families in the district are suffering from the fever, several of the cases having terminated fatally. Dr. Littlejohn is carefully watching the progress of the epidemic, and taking all the necessary precautions to prevent its spread.—*Med. Times and Gaz.,* Sept. 15, 1877.

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Chloral in Tetanus.—At a late meeting of the Paris Surgical Society, M. Gueniot read a report on a case communicated by M. Ganiez. The cause of the tetanic attack in this case was rare, as the disease became developed twenty-two days after an amputation of the breast. Large doses of chloral, twenty-five grammes (seven-eighths of an ounce), were given every twenty-four hours. On the fourth day the effect was so manifest that a speedy cure was anticipated; but the patient was not perfectly well before five weeks. About three and a half ounces of chloral were given altogether.—*Med. Examiner*, Sept. 13, 1877.

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Salicylic Acid in Pertussis.—Amidst the round of trials which salicylic acid is undergoing, may be mentioned its use in pertussis as recommended in the *Petersburg Med. Woch.*, Nos. 22 and 23. Inhalation of a 2 per cent. solution for five minutes every evening during the convulsive stage effects an immediate influence, a cure resulting, on the average, within two weeks.—*Med. Times and Gaz.*, Sept. 15, 1877.

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The Prophylaxis of Phthisis.—At the last meeting of the Paris Academy of Medicine, M. Lagneau read a paper, which was referred to the Committee on Hygiene, in which he advocated strongly the enforcement of measures of public hygiene, with a view to diminish the frequency of phthisis. This terrible scourge of the inhabitants of the temperate zone is, he showed, more prevalent in Paris than in Berlin and London, reaching a mortality of 18 per cent., a proportion in which it is exceeded by Brussels and Vienna. He pointed out that whereas formerly the male deaths from phthisis were less than the female, the proportion between the sexes has now become reversed, the male mortality being to the female as 115 to 100. Further, that the mortality was higher by one-fourth among the immigrant population (country folks and foreigners) than among the native Parisians. After alluding to the fact that the disease prevails in warm and cold climates, M. Lagneau pointed out that certain regions enjoyed an immunity, such as certain altitudes in the Alps, Pyrenees, Cordilleras, Andes, the Mexican plateau, and certain northern countries, as Iceland, the Hebrides, portions of the northwest of Scotland, and the Faroe Islands. Although the only point in common between these mountain districts and northern countries is the possession of a low temperature, he showed, however, that cold could not be considered as preventive of phthisis, for M. Homann has shown it to prevail at Christiansand, in 62° north latitude, with a mean annual temperature of 4.5° C. (40° F.), and MM. Etzel, Billebon, and Gueranlt report a certain proportion of deaths from pulmonary consumption in Greenland. In France itself a far larger number claim exemption from military service on account of chest disease in the northern departments, as those of the Nord and Pas du Calais, than in the rest of France; but there is likewise a fair proportion even in the Mediterranean departments, where sufferers are so often sent. M. Lagneau showed also that poverty and insufficient nourishment do not go hand in hand with phthisis, the inhabitants of those districts where the disease prevails being in much better circumstances than many others where phthisis is almost unknown. Pursuing his analysis further, he finds a general consensus of opinion among French authorities as to the favouring effect of sedentary occupations and trades; the department of Morbihan, which furnishes the fewest instances of the disease, being also the least industrial part of the country. He urged therefore the formation of free gymnasia, the encouragement of athletic exercises, formation of choral societies, establishment of public sanataria for the phthisical, prevention of overcrowding in workshops, and means taken to procure a good supply of air and light in newly built dwellings, legal restrictions against juvenile labour, the encouragement of physical exercises in the lycées and schools, and the substitution of rural camps in place of barracks, where the young soldier could pass his term of military service. —*Lancet*, Oct. 6, 1877.

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Sanitary Science and its Practical Results.—A portion of the address delivered at Aberdeen by Dr. Edwin Chadwick, President of the Public Health Section of the

Social Science Association, consisted of an exposition of the results produced by the application of the principles of sanitary science in the prolongation of human life and the prevention of disease. He very happily put the subject in the form of a hypothetical contrast; pointing out that, on the one hand, by closely copying certain notorious localities, both in Great Britain and on the Continent and America, with all their unsanitary conditions, a city might be built which should present an annual mortality of more than 40 per 1000; in which more than half of those born should die before the fifth year; and in which there should be a general moral and physical deterioration of the survivors. That these results could be produced, was proved by their existence under the conditions referred to. On the other hand, the application of sanitary knowledge had produced, and might produce, results which were thus summarized by Mr. Chadwick. 1. We have gained the power of reducing the sickness and death-rates in most old cities by at least one-third; or, as a rule, of reducing the death-rates in old British urban districts to 16 or 17 in 1000. 2. In new districts, on sites apart from old urban sites, we may, with a complete arterial system of water-supply and surface-cleansing—including measures for the prevention of overcrowding—insure reduction of death-rates to less than one-half, or to a mean rate of 10 in 1000, and the sickness in the like proportion. 3. In well-provided and well-regulated institutions for children from three to fifteen years of age, we may secure them an immunity from the common children's epidemics, and reduce the death-rates to a mean of about 3 in 1000. 4. In prisons and places under effective sanitary control, the death-rates (from disease) have been reduced amongst persons from the school ages and upwards to about 3 in 1000, or to one-third of the death-rates prevalent amongst the general population of the same ages. 5. To the persons in such institutions an immunity may be given against all ordinary epidemics, typhus and the eruptive diseases, diarrhœa, and dysentery, which ravage the general population. 6. Amongst the general population a reduction by fully one-half of the diseases of the respiratory organs may be effected by general public sanitation. 7. Complete habits of skin-cleanliness, alone and apart from general structural arrangements, or alterations of habits in other respects, constitute a factor of about one-third of the power of sanitation. 8. By a proper selection and a due sanitation of sites in tropical climates, and the sanitary care of the population, the birth-rates may be made to exceed the death-rates, and a healthy succession secured for colonization, for people of the British or of the white races. 9. By the increased health and strength imparted by improved physical training under sanitary conditions, on the half-school-time principle, in the infantile and juvenile stages, the efficiency of three for productive occupation may be imparted to every two of the most depressed classes of the population. 10. The death-rates from disease in the mercantile marine may, by the exercise of the like powers of sanitation that are exercised in the Royal Navy, be reduced by two-thirds, or to the general death-rate now prevalent in the Royal Navy, namely, about 6 in 1000. 11. As indicated by existing normals, the greatly reduced death-rates in the army at home and abroad admit of important further reductions, by a more complete application of tried and approved means of sanitation.—*British Med. Journal*, Sept. 29, 1877.

Death from Bichloride of Methylene.—Another case of this has occurred at the Radcliffe Infirmary, Oxford. A young man was operated on for disease of the bones of the foot, and amputation was performed above the ankle-joint. Bichloride of methylene was administered on lint. Before the dressing of the stump was completed, it was observed that the patient was pulseless, and that respiration had ceased. Artificial respiration was attempted, but, unhappily, without success. A case of death during anæsthesia occurred at this Infirmary about five years ago.—*Med. Times and Gaz*, Sept. 22, 1877.

Composition of Quack Medicines.—This is not a secret with regard to most of these, thousands of analyses by competent chemists having supplied revelations that would fill volumes. This is, however, of no avail, for neither the chemists nor governments are disposed to incur the expenses which would be required to make known the deceptions of these widely advertised compounds. Richter states that among 938 secret remedies analyzed by him, he found (1) 22 per cent. contained substances of violent or poisonous action; and (2) 25 per cent. which, although less active, yet were possessed of medicinal power; while (3) 52 per cent. were of no importance, or quite inoffensive. The first category especially comprises violent and poisonous agents for the skin and hair; opiates for children, capable of inducing chronic cerebral disease or even death; "purifiers of the blood," composed of arsenic or mercury; and a whole legion of violent purgatives capable of doing in inappropriate cases an immense amount of mischief. The third category comprises preparations which have nothing in common with the noxious and poisonous effects produced by those of the first and second, but yet agree with them in being sold at from five to a hundred times their proper value, and thus constituting robberies. All these attacks on the public health and morals take place with the full cognizance of the public authorities.—*Med Times and Gaz.*, Sept. 15, 1877, from *Lyon Méd.*, Sept. 2.

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The International Medical Congress, Geneva, 1877.—The International Medical Congress was opened at Geneva, on September 9th, by an address of welcome from Professor Charles Vogt, President of the Committee of Organization, in the hall of the University. Almost all the nationalities of Europe as well as the United States of America and Mexico were represented by delegates.

The organization of the Congress was completed by the election of the following officers:—

President, Prof. Charles Vogt, of Geneva; *Honorary Presidents*, Professors Bouillaud, Verneuil, Ollier (of Lyons), Letievant (of Lyons), and Lebert.

Vice-President, Dr. H. Cl. Lombard, of Geneva.

Honorary Vice-President, M. Marey.

Secretary-General, Dr. Prévost, of Geneva.

The Congress was subdivided into six Sections as follows: Medicine, President, M. Strœhlin; Surgery, President, Dr. Mayor; Midwifery and Gynæcology, President, Dr. Gautier; Public Medicine, President, Dr. H. Cl. Lombard; Biology, President, Dr. M. Schiff; Ophthalmology and Otology, President, Dr. Warlomont, of Brussels.

A number of interesting papers, which elicited instructive discussions, were read and abstracts of the more important of them will appear elsewhere.

It was determined that the next Congress shall be held in Holland.

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Canada Medical Association.—The annual meeting of this Association was opened at Montreal on the 12th of September, by the President, Dr. Hingston, of Montreal. The profession of the United States was represented by Drs. Kimball, of Lowell, Wing, of Boston, and Brodie, of Detroit, delegates from the American Medical Association, and Dr. Adams, of Island Pond, delegate from the Maine Medical Society. The Association remained in session two days, and several interesting papers were read. Dr. Joseph Workman, of Toronto, was elected President for the ensuing year, and the next annual meeting will be held in the city of Hamilton.

—

Dr. Matthews Duncan.—The profession in London is again to receive an accession of strength from Edinburgh. Dr. Matthews Duncan has accepted the post of Obstetric Physician to St. Bartholomew's Hospital vacated by the resignation of Dr. Greenhalgh. Dr. Duncan is a very popular and influential teacher, and his loss will be greatly regretted at Edinburgh.

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Considerably more space than we can allow to it would be required to give a notice worthy of this admirable work. The author has become well known as an authority on the affections of the organ of hearing; and the volume which, after considerable preparation, he now offers to the medical profession, completely justifies his reputation. The number of references to the literature of the subject is very large, and correspondingly valuable.—*New Remedies*, Oct. '77.

This text-book is prepared by an author of great distinction in his specialty, both as a practitioner and a teacher. His right to this distinction is manifest from an examination of the work he now presents the profession. We are constrained to give this book a cordial recommendation.—*Va. Med. Monthly*, Oct. 1877.

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None can read it without being impressed with the immense amount of common-sense which is possessed by the author, as well as natural tact in interpreting the indications of treatment. His style is clear and agreeable, and he has the faculty of expounding the fundamental principles of medicine in such a way as to give them a practical application to treatment. It is, in fact, one of the most interesting, entertaining, and instructive works of its kind that we have ever read.—*Med. Record*, March 17, 1877.

We must say that it is long since we have read so attractive, practical, and valuable a work. It is one that will bear long and close acquaintance, and the more often it is read, and the closer it is studied, the more will its value be appreciated by the practitioner, and the more will the latter become of value to his patient. Watson and Chambers have heretofore been our favorite English medical authors; we now add Fothergill to this list of charming, practical, indispensable writers.—*St. Louis Clinical Record*, April, 1877.

This is a very valuable book, and is well adapted for a young practitioner. We have every reason to thank the author for a practical and suggestive work.—*London Lancet*, March 24, 1877.

He has succeeded in producing a volume that will be found an exceedingly useful companion to the standard works on practice. It abounds in information of value at the bedside, and is eminently practical throughout. — *N. Y. Med. Journ.*, April, 1877.

HENRY C. LEA—Philadelphia.

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CLINICS.

ORIGINAL CLINICAL LECTURES.

Clinical Lecture on Nervousness in the Male. By S. Weir Mitchell, M.D., Physician to the Philadelphia Infirmary for Nervous Diseases.

Many years ago, when we first began to sum up and classify the cases which came to my clinic, at the Infirmary for Diseases of the Nervous System, my assistants called my attention to the large number set down as general nervousness; and I then saw, with some surprise, that so very many of these were men. This was the more notable, because of course the persons who seek help at the Infirmary are mechanics and workingmen chiefly, and therefore hardly such as are presumed to suffer from nervousness.

Under more exact study, by means of referring the cases back to their causes, the number labelled general nervousness has been somewhat lessened, but in each year's report still appears a group in which either general nervousness is the dominant condition, or which at all events I find myself unable to classify under any other heading.

We rarely see this condition delineated in the books. You may read whole text-books about nervous diseases, and see no mention of this striking, this annoying, this disabling condition; or, if spoken of at all, it is as if it were entirely the sad prerogative of woman. We may find it useful, therefore, to look back over some of our cases to see how they originate, what precisely are their symptoms, and to what extent and in what manner we have power to relieve them.

In so doing I do not desire to be considered as wishing to make of general

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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nervousness a disease. Yet does it sometimes present itself here and elsewhere, with so little apparent relation to causal conditions, and with so distinct a group of clinical peculiarities that it is at times hard to do otherwise than so to treat it. For the most part it is the offspring of obvious defects in the nutritive supply, and is plainly related to coincident or precedent changes in the nervous or vascular systems. Sometimes too it is ephemeral, sometimes it is only too lasting, and in a few cases it is due to original defects, and arising at birth is carried to the grave.

As concerns many other symptoms, so also of this. It does not answer to accept the statement of the patient that he is nervous; we want also to know what he means by nervousness; and this brings me to the definition of the term. Perhaps a couple of illustrations may aid us in this study. The first I shall offer is a very good example of a somewhat rare cause of this state, and is a type of the complex symptom or disorder as perfect as we can desire.

C. J., æt. 28, about 5 feet 10 inches high, and weighing 135 lbs., tells me this story: At the age of eighteen he was well, active, and of rather cool and quiet temperament; not in the least a nervous lad. At this time he began to learn segar making, and has been at the trade until a year ago, when he gave it up. He has been in all ways temperate, and curiously enough has not learned to smoke or chew. This trade has, however, been, in my opinion, disastrous to his nervous system, and this is not an exceptional case, as I have seen others who had been in like manner injured by the same occupation. By slow degrees, but more and more each year, this young man has developed a nervous constitution, which he attributes to the work he did, a conclusion in which I fully agree. At last it drove him from the trade, and now he is here for relief. Let us look at the range of symptoms he presents.

He is sallow, and inclines to anæmia. His appetite is fair, his digestion uncertain, good to-day, bad to-morrow; his bowels much like his digestion. I can detect no renal or intestinal disease, and he has never had ague or syphilis. His circulation is poor; his heart feeble; it beats when he is lying down 85, and rises abruptly to 100 when he stands up. A sudden sound, a slight scare, an unlooked for visitor, gives him palpitation of the heart, sense of throbbing in the limbs, and coldness of hands and feet, with local sweats.

He has become emotional also, and gives way readily to grief, or to mirth. He sleeps ill, dreams much, and is liable like a child to night terrors. As to exercise he can work as well as ever, but thinks he tires more than he should do; and he adds finally, I used to be as brave as any body, but now I am afraid of everything. Since he gave up segar making he has been slowly gaining ground, under the use of a variety of tonics.

As a second illustration I turn to my note-books kept during our late civil war.

C. J., æt. 30, a large, vigorous man, was one of the leaders of the gallant storming party which took Fort Fisher. He had, before this, led a life of adventure and danger. Probably it would have been hard to find a more cool, quiet, resolute soldier. He was shot through the right lung, and the ball emerging entered the arm, and injured the median nerve. He had a long series of lung troubles, and the terrible anguish of causalgia (burning pain) in the hand, exhausting suppuration, and constant pain, reduced him in three months to a slightly covered skeleton, and transformed him morally into a peevish, timid child. In this condition he was a type of a nervous man. A sudden noise, an unlooked for letter, the morning visit of the doctor, set his heart beating and made his limbs cold. At the prospect of a hypodermic injection he would shed tears, and he became annoyingly susceptible to the irritative influence of sounds and light.

When we come to ask in what general nervousness consists we shall find, I think, that its prominent peculiarity lies in over-excitability. This is not all of it, but it is a large, perhaps the largest part. The patient is too easily moved, too readily excited. The strong man becomes like the average woman, the woman like the unschooled child, and the symptoms for the most part are not utterly abnormal, but are exaggerations of normal conditions. Many of the characteristics exhibited by the nervous man on the slighest provocation are seen in the normal man at times on rare occasions, under exposure to unusual emotion. A nervous man receives a telegram; he becomes pale, his heart throbs, and he opens the envelope with a trembling hand. It proves to be a message of no moment, but the effects last for an hour. A healthy man might have shown like disturbance under the influence of some sudden announcement of the gravest calamity, while we shall meet with men who under no circumstances show the least outward sign of emotion while in health. The mass of men are naturally free from nervousness, and perhaps the hardening education which the man undergoes is a means of forcing him to repress emotion and to restrain the exhibition of feeling until restraint develops habit. On the other hand, the lonelier lives led by women leave them more free in this respect, and all their training lies too much in the opposite direction to that of men. In either sex early education may do much to restrain acquired or inherited nervousness, while it is quite sure, as I have many times seen, that the most hardy children may be made nervous and emotional by over-indulgence, and by allowing them to grow up without having learned this life's most urgent lesson, that of self-restraint. I have said that the condition I call general nervousness is mainly characterized by a certain readiness to be excited, and it remains to point out the rest of the clinical peculiarities which go to make up a picture which it is perhaps difficult to make sharply definite. With the tendency to be easily moved there is also a certain apprehensiveness which applies both to the possible effects of outside influences, and to the symptoms of the patient himself. What he feels, he exaggerates, and he is alarmed by what he feels; knowing also how certain agencies affect him, he dreads them, and thus learns to shun his fellows and so to avoid the incidents which contact with men brings about. Very nervous persons are also apt to suffer from a sense of confusion upon sudden or prolonged use of the mind, and from being in a crowd, or where there are many speakers.

In all such men, anxiety, fear, embarrassment, are prone to occasion some disturbances in the sphere of motor activities, which are, to begin with, never, in such cases, quite what they should be. Thus in acquired nervousness, the hand is apt to become tremulous, and under emotion of any kind this may increase, so that, when conscious of being observed, it becomes impossible even to sign the name. Under more violent emotion greater disturbances may occur and the tremors become larger, and even pass into the degree of spasm, local or general. All painful emotion is competent more or less to disturb and enfeeble the normal capacity for movement, and in nervous people emotion becomes doubly capable of weakening the limbs, of affecting the speech, even to inhibition of vocal utterance, and of showing itself in the play of the features.

In some cases, the mental or emotional impression disturbs the vaso-motor system, and we have then spasm or dilatation of vessels, violent arterial throbbing, irregular and excited cardiac action. How the extreme of nervousness acts on the battle-field is well known. Sometimes like annoyance is occasioned in acquired nervousness, and emotion provokes urination or motion of the bowels. I have seen more than one nervous man who on leaving home in the morning would be turned back again and again to make water. Mr. Carpenter has long since called attention to the fact that when we watch our automatic movements, and try to make them voluntary, we at once make them difficult. As in nervous people too much attention is apt to be paid to the processes which go on in the body, we find in them in an exaggerated degree just such difficulties in the act of swallowing, of micturition, and, as I have said above, in those grouped habitual movements, such as writing, which have become almost automatic. Exaggerated states of nervousness give rise in men, as in women, to the motor disturbances, which are said to characterize hysteria, and even to many of the psychical peculiarities of that strange state, although only once have I seen a man exhibit the whole range of these phenomena.

The sleep of men in this condition is rarely good, nearly always they go to sleep with difficulty, dream unpleasant dreams, and wake often or early.

When we come to ask ourselves what is the state of the nerve structures which gives rise to the symptoms described, we are somewhat at a loss. It is easy in a large majority of cases to feel sure that it is, however caused, a state of feeble or tardy nutrition with which we have to deal, that it is in turn associated as usual with an extremely unstable state of circulation in the nerve centres, so that states of congestion at one time, and at another of anæmia from vasal spasms may prevail; but, if we seek beyond obvious clinical conclusions to determine just how the nerve cells are changed, we are forced to pause and admit that the theory of feeble nutritive supply fails to explain many of the cases of sudden nervousness such as those which arise from mental shock. I saw a curious case of this kind some years ago.

A young man, æt. 18, while attending his father's funeral, slipped on the wet ground and fell into the grave. From this time he became strangely nervous, was startled readily, grew timid and apprehensive, and at last became unable to write while any one was watching the act. The tremor thus caused at last so increased that he had to give up a clerkship which he held. This condition of system came as it were in a moment, and converted a quiet somewhat resolute person into a nervous invalid. I might quote other cases, the one I have given may suffice. This man remained in good physical health, and was thus in contrast with most cases of acquired nervousness, which as I have already said are at least associated with states of feebleness, if they be not always traceable to these, but although such is distinctly true, the form of trouble causing weakness, innutrition, and anæmia varies, and with its variation the intensity of the nervousness, and even its quality varies. Nor must we lose sight at any time of the character of the patient, for this also must make up a part of the case, and it will be one thing to deal with a case of congenital nervousness made worse by circumstance, and quite another to treat a person at one time firm and cool, and who has merely become nervous through disease or suffering.

It may repay us to run over the causes of nervousness, with such illustrations as our case books afford.

I have mentioned already one case as an illustration of the influence of enfeebling wounds. In like manner we find sometimes extreme cases of nervousness following fevers or exhausting diarrhœas. Every old army surgeon, who recalls the Chickahominy diarrhœas, will recall too the dreadful condition of nervousness to which it reduced many persons.

The connection of general nervousness with neural maladies is also of interest. The victims of general sclerosis, and still more those of paralysis agitans, are apt to suffer horribly from acquired nervousness, while in posterior sclerosis (locomotor ataxy) the patients are often singularly free from nervousness, unless they continue to suffer from the atrocious pain which sometimes continues throughout the whole course of the disease. It is amazing to learn the extent of brain disease which may exist without making the sufferer excitable, timid, tremulous, or in a word nervous. So much may also be said of many cases of brain tumours, and of very many hemiplegias, while affections of the pons and of the sensory tracts, involving hemianæsthesia with pain or obscure unilateral sensations of burning are sure to cause horrible nervousness.

How far visceral disease may cause it depends a good deal on the individual, but more on the organ attacked, as we well know. A poet has said "hope springs eternal in the human breast," and certainly, to judge from the psychical peculiarities of pulmonary disease, he was fully justified. On the other hand, the nervousness and depression which accompany disorders of the abdominal viscera are well known, and gave rise to the adage of the Presbyterian divine that "no man dies a triumphant death who dies of disease below the diaphragm."

The genito-urinary tract in man furnishes in disease remarkable illustrations of the extreme of general nervousness. Distressing examples are supplied by some of the many cases of seminal emissions which we see, and sometimes sexual excesses give us equally signal instances.

The worst cases I have seen were those of sexual excess in the young. I was consulted four years ago by a gentleman, aged 27, from Tennessee, who told me, that when a mere lad he cohabited with a girl several years his senior, and the intercourse was kept up without suspicion until the girl had become a teacher, and the lad was himself seventeen years old. At this time he ceased to see her, but the mischief was done. From the age of thirteen, he had become excitable, emotional, and tremulous on the least sudden noise or mental shock. This increased so, that when he left school at seventeen, he began to shun society owing to his want of self-control. He then improved during a year spent in the country, but the work and confinement of a counting-house again brought back his old trouble, and he began, after two years, to lose the power to write owing to increasing tremor of the hands; a more distressing case I never saw.

Nervousness is a frequent accompaniment of that form of head trouble, about which there are so many theories, but which is most common in the young, or at the close of middle age. I presume that the term nervous exhaustion is as good a label as any. It does not always lead to great nervousness, but it does do so sometimes, as in this rather curious case, which I saw but lately.

M. L., æt. 58, the leader of the bar in a Western city, was forced some years ago to carry on the trial of a most important case, while his wife lay dangerously ill. From this time he began to find that he felt embarrassed when rising to speak, and that he was obliged to urinate always before speaking in court. The mere knowledge of these facts began to trouble him, and soon after he found that his emotions were less under control than they had been. At last one day when about to sign his name, he found that his hand shook, because two gentlemen who were to act as witnesses were watching him. From this time he could no longer write, when overlooked, unless he made the most earnest effort. With these disabling conditions, he began to fail in vigour and appetite, and to become excessively restless and irritable. Under fortifying treatment with long absence from home he became entirely well.

While epileptics are often quite free from nervousness, frequent attacks of vertigo, whether due to aural disease or to other causes, are almost certain to result in general nervousness of the most distressing kind. Where vertigo occasions the condition which I recently described (*Med. Reporter*, lecture on Vertigo) as the vertiginous status, this is notably the case. In this state frequent onsets of vertigo give rise to a permanent sense of instability, and also to confusion whenever prolonged or intense thought is attempted. This I venture to call mental vertigo.

Tobacco is of all causes the most potent in giving rise to general nervousness. Used in excess it makes the heart irritable and feeble, produces tremor and insomnia, and may develop even in sturdy people a high type of nervousness. Its potency is singularly well seen in its effects on people by nature nervous, and in the remarkable manner in which it disturbs many ataxic patients, or those who have paralysis agitans.

I have now an ataxic case which well illustrates this peculiarity. The patient has ceased to have pain, and seems for years to have been at a stand-still. He has made one of those curious pauses in the disease which flatter the patient with the hope of recovery and delude too hopeful therapeutists. The patient is excessively fond of tobacco, and despite all that it costs him will now and then venture to try it again. The result is interesting and always the same. He becomes, after two segars, so emotional that noise, a telegram, a letter to be opened unnerve him, and his voice fails if he has to address a stranger. He acquires tremor of the hands, and writing becomes impossible for a day or more.

Here also is a strange example of neurotic states in the male caused by, first, a peculiar constitution, and, secondly, by extreme abuse of tobacco. Had it been a woman's case, no one would have failed to label it hysteria.

P. L. T., æt. 24, a young merchant, belonged to a family, which offered in the last generation two cases of melancholia and one of epilepsy. Mr. T. was the sole remaining representative. He was always a delicate looking man, of nervous temperament, quick, restless, and anxious. At the age of sixteen years he began to chew and to smoke, and used tobacco in both forms to excess—up to his twenty-third year, when I saw him first. I learned then that he had become more and more nervous, and had twice had fits of alternate tears and laughter, seemingly quite uncontrollable. The night I saw him, he had had a fall, from which he did not rise, but called for help, insisted that his thigh was broken, and was at last carried home on an extemporized litter. When I examined him, his right leg was rigid, the foot extended. The spasm lasted for some hours, while I sat and watched him. When it gave way and the legs began to twitch, he had a general convulsion, then a period of apparent insensibility, then a series of such fits, and at last a remarkable condition of general rigidity. The series ended with an enormous flow of thin and pale urine.

These phenomena recurred at intervals for two years, and I have over and over witnessed in him nearly the whole range of hysterical symptoms. His last attack began with fits of crying, and ended in hemi-anæsthesia and partial loss of power on the same side.

Mr. L. was made well by giving up tobacco, and by a long course of careful physical training.

Among the most potent causes of general nervousness in man, as in woman, is a state of anæmia. It is probably the immediate cause in some of the cases credited to pain—to exhausting discharges, and to maladies of assimilation, to which I have already alluded, and at all events it is a condition never to be lost sight of in the treatment. A remarkable example is to be found in the case of Mr. L. P——, recorded at p. 89 of my little book on *Fat and Blood*, second edition. In this instance the anæmia was remarkable, and the nervousness not less notable.

I have seen children reduced to a state of pitiable nervousness, with feebleness of will and convulsive states not epileptic, owing to unsuspected albuminuria. I am now attending such a case in a lad of the age of thirteen.

I am unwiliing to end without some allusion to treatment, but as to this I must be brief.

A large part of the treatment of nervousness must, of course, resolve itself into the treatment of anæmia, of defects of nutrition, of mal-assimilation, of dyspepsia. I have said that, in one way or another, poverty of blood is most often the true difficulty. It may be due in turn to this cause or to that, but when these have been cured, or helped, there will yet be left the anæmic state, and in some people, when this exists, it is strangely intractable. On this matter, however, I have nothing to add here to what I have recently said concerning the treatment of obstinate states of anæmia,[1] either with or without loss of flesh. The slighter grades are, of course, to be met in the usual ways familiar to all physicians.

But nervousness, whatever be its parentage, demands something more than this. Only too often the symptoms, which make up this annoying state, continue after we have amended the blood losses, which undoubtedly occasioned them. There is, perhaps, in this fact but another example of the persistency of morbid habits. The man whose self-confidence has once been rudely shaken does not speedily reacquire hardihood in the face of disturbing impressions, and we have also to deal with the many instances of nervousness which arise out of moral causes or are of unknown birth. In the cases of women, we can often aid by secluding them for a time from the kind of troubles which keep up the habit; and with men we may reach the same end by cutting them off from their routine lives, through the help of travel and change of scene. Above all, it is useful to give to such persons the out-door life of field sports; and where these cannot be had, it is often wise to induce the sufferer to undergo some gradual course of physical training, since this has in many cases the happiest results. I have over and over again seen the most helplessly nervous men lose their annoyances under such a plan, but it requires both care and patience, because almost all of the more systematic means of physical training are tiresome, and excite none of the interest which belongs to the exercises of out-door life. The difficulty vanishes in the presence of ample means. Said a gentleman to me yesterday, "Colorado in summer, and horseback in winter—these are what cured me of nervousness."

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[1] Fat and Blood—Rest in the Treatment of Nervous Diseases. Lecture—Séguin's Series.

The mental attitudes of the nervous man demand of his physician the most careful attention, nor can we afford to disregard anything in his ways of life or his habits of thought and action. We must determine for him how far and how much he shall use his mind; whether or not it is well for him to continue his work, whatever it be, what his amusements should be. The careful student of such cases will find in the individuality of his cases the need for the most minute of such studies, and, above all, he will learn that the more fully he commands the confidence of his patient the more can he effect. Such people are greatly helped by a word or two of decisive promise or of reassurance, and since a part of the treatment of the acquired habit of nervousness must consist in mental and moral training, it becomes needful at times to make the patient comprehend that he himself has some control over his symptoms, or, at least, that constantly to yield to them is to insure defeat, and that constantly to struggle in a manly way is sure to bring nearer the day of perfect self-conquest.

But, besides these obvious means, we have some agents, the careful employment of which is of essential value in general nervousness. First among them is the use of water in its varied forms of application, a too much neglected therapeutic aid. We have no water-cures in this country conducted on scientific principles, and by men of experience and intelligence, yet much may be done by the aid of the shower-bath, the douche, and the pack in the patient's own home. Alcohol would also have its use, and, indeed, has its use, but it is so immediate and perfect a relief to many people who are physically nervous, that I for one often fear to use it.

Then come the drugs. There is a form of cardiac and vasal irritability which is found in many nervous people, and which is most distressing. I have now a patient who never receives a guest, or even the best known visitor, without becoming pale, even white to faintness, and without having the most violent palpitations. Another never opens a letter without like symptoms. In such cases full doses of digitalis, long kept up, are most valuable, and are in many cases capable of helping to form a habit of insensibility to such influences when once we have succeeded in bringing the nutritive system into perfect condition.

Digitalis has, I think, no power to aid the other symptoms of general nervousness. It helps the vasal and cardiac troubles, but not the tremor nor yet the mental symptoms, the indecision, the shyness, the timidity, the self-consciousness, as alcohol does, at least for the time.

Of more general value are both opium and cannabis, but neither ought to be used very long, and when taking them the patient should not know what he is taking, and, above all, they should be used in very small doses, and perhaps I ought to say what I mean by small doses. In such cases I give of morphia $\frac{1}{20}$ grain, with $\frac{1}{20}$ of cannabis, and a varying amount of aloæ ex. or rhubarb, and if these doses are too strongly felt, I give even a less amount.

Among the general nerve tonics arsenic stands high, but the secret of its use lies in its long continuance. The bromides are also of the utmost utility. Among them I prefer the lithium bromide, which I introduced into medical use some years ago, and which has now stood the test of my own longer experience, as well as that of many French and German therapeutists, who have come to regard it as the most valuable of the bromides. It should be given in some simple bitter for many months, and in doses of not more than five or ten grains, thrice a day. I often use the bromide of lithium and the bromide of arsenic together in solution.

The valerianates have also their uses, and I am fond of combining the three valerianates of quinia, zinc, and strychnia in the pill form. I am much more doubtful of the prolonged usefulness of such agents as assafœtida and sumbul, which, however, are often effective to tide over periods of increased nervousness.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

A Private Medical Home for Opium Habitués.—Parrish Hall, Brooklyn, N. Y., which has just been opened, offers to those of either sex, who may desire to avail themselves of its advantages, an asylum for the treatment of the disorder to which it is *exclusively* devoted. It is beautifully situated in a suburb of Brooklyn, and it is intended to make it an attractive home for its inmates.

Patients will be treated by reducing their supply of opium to that amount which will suffice without suffering, and thenceforward its decrease, in quantity more or less minute, according to the degree of discomfort attending its withdrawal, meanwhile sustaining and soothing the nervous system by a judicious employment of tonics and nervines, with such other therapeutical measures as the exigencies of each particular case may seem to demand.

Drs. J. B. Mattison and A. M. Mathias are the physicians in charge.

Physicians' Visiting Lists, Prescription Blank Books, and Ledgers.—Several rival publications appear this year to claim professional favour. Lindsay & Blakiston's old established and deservedly popular "Visiting List," which is too well known to require any words of introduction, enters upon its twenty-seventh year.

J. B. Lippincott & Co. have just issued "Wood's Physicians' Vade-Mecum and Visiting List," which, as it is without dates, answers equally well for any year. It is neatly gotten up, and contains twenty-four printed pages of information which may be valuable in emergencies.

"Walsh's Physicians' Combined Call-Book and Tablet" (Washington), as regards general arrangement, is in many respects similar to the preceding.

Robert Clarke & Co. have published the "Physician's Pocket Case-Record and Prescription Blank Book." It is a pocket-book of prescription blanks with stubs with appropriate headings for clinical notes, and it also contains a visiting list. The same firm has also published for office use a quarto book similarly arranged, containing three prescription blanks on a page.

"Walsh's Physicians' Handy-Ledger" will be found very convenient by the busy practitioner. The method adopted is so complete, simple, and handy that the Ledger cannot fail to become popular.

Obituary Record.—At Nashville, Ten., on the 3d of November, aged 71, Paul F. Eve, M.D., Professor of Operative and Clinical Surgery in the University of Nashville.

Prof. Eve was widely and favourably known as a surgeon of vast experience and of considerable learning. In 1857 he was chosen President of the American Medical Association. He was the compiler of an interesting "Collection of Remarkable Cases in Surgery," an octavo volume of over 800 pages, published in 1857. For many years he was the editor of the Nashville Journal of Medicine and Surgery. His last contribution to the literature of his profession was his address on Surgery at the International Medical Congress of 1876.

Dr. Eve was attacked with apoplexy at a patient's bed-side and only survived a few hours.

FOREIGN INTELLIGENCE.

Falling-out of Hair.—Prof. Erasmus Wilson, in cases of defluvium capillorum, prescribes a lotion composed of strong liquor ammoniæ, almond oil, and chloroform, of each one part diluted with five parts of spirits of wine or spirits of rosemary, and made pleasant as to fragrancy by the addition of a drachm of the essential oil of lemons. This should be dabbed upon the scalp after thorough friction with the hair-brush. No doubt there are cases in which this lotion must be used with caution, or largely diluted. In cases of alopecia he recommends frictions with a liniment composed of equal parts of the liniments of camphor, ammonia, chloroform, and aconite, to be well rubbed into the bare places daily.—*Med. Record*, Aug. 25, 1877.

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Cerebral Thermometry.—M. Broca communicated to the Association Française pour l'Avancement des Sciences, which was sitting at Havre towards the end of last month, an interesting paper on the above subject. We are indebted to our contemporary *Le Progrès Médical*, No. 36, for the following details. M. Broca believes that thermometry wlll become a valuable aid in the diagnosis of brain disease. He uses very delicate thermometers, and, after applying them to corresponding positions on the two sides, covers with wool the part of the bulb which is not in contact with the skull, in order to guard against any thermic influence which the surrounding air might exercise. M. Broca has usually employed six thermometers, which were placed in sets of three pairs on corresponding parts of the skull. The anterior pair were placed directly behind the orbital apophyses, the middle pair above the ear, and the posterior pair in the occipital region. His first care was, of course, to obtain the average temperature, and to this end he tested the temperature of his *internes* and dressers at the hospital. He found that the maximum temperature of the brain was 34.85° C., and the minimum 32.80° C., the *mean* temperature therefore being 33.82° C. But, further, he found that the thermometers on the *left* side invariably marked a *higher* temperature than those on the *right* side. Thus, on the right side the mean temperature was 33.90°, while on the left side it was a little over 34°. The difference was found to average about one-tenth of a degree; *but this difference is only found when and so long as the brain is at rest.* When the brain is active the equilibrium tends to establish itself, and the temperature figures correspond. M. Broca argues that the left hemisphere is more freely supplied with blood than the right, and that the latter, less prepared and less apt, when brain-work has to be done, requires a larger supply of blood than the left, and hence the temperature on the two sides becomes equalized. Further, M. Broca has found that not only on the two sides of the brain is there a difference, but that this extends to different lobes of the same side; thus he has shown that the temperature of the occipital lobe was only 32.92° C., that of the temporal lobe was 33.72° C., and of the frontal lobe 35.28° C., which is accounted for by the greater functional activity of the latter. Then when the brain is actually working there is a rise of temperature; thus, after reading aloud for ten minutes a rise of about *one half of a degree* can be shown. The clinical bearings of these observations are not less important. M. Broca considers that the thermometer supplies an additional and an important sign of cerebral embolism; he can even diagnose the part of the brain which is deprived of its blood. As the result of his observations, it appears that at the level of an embolism there is a decrease in the temperature. The subject is necessarily in its infancy at present, but with the aid and example of such an authority on matters craniological as M. Broca, we shall hope shortly to be in a position to publish more extensive details. —*Med. Times and Gaz.*, Sept. 15, 1877.

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Cholera from the Laundry.—Incidents confirming the belief that diseases are spread by laundries are constantly reported to us as occurring, not only in England, but also on the continent, and our efforts at reform in this respect have been generally approved abroad as well as at home. Dr. H. Lebert, corresponding member of the French Institute, and recently Professor of the Breslau University, has informed us of several cases which, occurring under his own observations, further illustrate the dangers we have attempted to describe. The last epidemic of cholera which afflicted the inhabitants of Zurich was, it appears, traced to a washerwoman. Without hesitating, and without employing any special precaution, this woman washed the linen belonging to a child who had been ill with cholera, and, as the penalty of her imprudence, contracted the disease, and died from it. The germs thus sown in the laundry were soon propagated, first to the inhabitants of the street, to the washerwoman's immediate neighbours and customers, the scourge afterwards spreading all over the town. Previously there had been no case whatsoever of cholera. It attacked first the child, and was then spread throughout the town by the washerwoman. At Branson, near Martigny, in French Switzerland, Dr. Lebert was acquainted with a sister of charity, who took excellent care of some persons suffering from cholera. When the epidemic was over, the sister devoted herself to washing the linen of her patients. She had escaped the infection in the execution of her duties as a nurse, but fell ill after washing the clothes, and died. The loss of this valuable life was due, therefore, to the want of proper means of disinfection. Finally, Dr. Lebert relates that four washerwomen employed to cleanse the linen belonging to the Breslau Hospital contracted typhoid fever. These women lived in different quarters of the town, but they had all washed linen taken from typhoid patients; thus it is probable that they were also victims of the carelessness so universally displayed when dealing with soiled linen. It is very unlikely that four washerwomen, each living in different parts of the town, would all have simultaneously fallen ill with the same disease, but for the fact that they were brought into personal and prolonged contact with what would appear to have been contaminated clothing.—*Lancet*, Oct. 27, 1877.

The British and Foreign Medico-Chirurgical Review.—We regret to find in the October number of the *British and Foreign* the announcement of the discontinuance of this well-known periodical. Commenced thirty-eight years ago, under the able editorship of the late Sir John Forbes, it soon deservedly attained the high position in medical literature which it held for a long number of years. Its reviews were able and learned expositions of the subjects of which they treated, and were contributed by authors who were themselves leaders in the science of the day.

Under the successive editorships of Sir John Forbes, Dr. Parkes, Dr. Carpenter, Dr. Sieveking, and Dr. J. W. Ogle, and with such able contributors as Neil Arnott, William Baly, Golding Bird, George Budd, Sir James Clark, Wharton Jones, Aston Key, Sir Ranald Martin, Richard Owen, William Sharpey, and others of like distinction, it would appear unnecessary to say that the "Review" fully met the needs of the students in the profession.

In seeking for a cause for the late decline in its circulation, until it has finally reached a period "when to continue to publish it would incur an annual loss," the publishers assign it to be in that "a quarterly, with its thoughtful articles and well-digested reviews, is no longer appreciated as formerly." We should be sorry to think this of the present generation of medical men in Great Britain. The true cause, we are inclined to believe, is, and we regret to say it, the well-known fact that of late years there has been a most noticeable decadence in the ability displayed in the pages of the "Review," until it has at last ceased to be, as it was of old, indispensable to its *clientèle*. The many readers of the "Review" in this country, who had hoped that it would again see better days, will be sorry to learn of its discontinuance.

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The Chair of Clinical Surgery in the University of Edinburgh.—Mr. Thomas Annandale has been appointed to fill the vacancy created by the transfer of Mr. Lister to London. Mr. Annandale is an adherent of the antiseptic method.

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THE

MEDICAL NEWS.

MDCCCLXXVIII.

VOL. XXXVI.

PHILADELPHIA:
HENRY C. LEA.
1878.

PHILADELPHIA:
COLLINS, PRINTER

MAR 1 19

THE MEDICAL NEWS AND LIBRARY.

VOL. XXXVI. JANUARY, 1878. No. 421.

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CLINICAL LECTURES.

ON THE LATERAL OPERATION OF LITHOTOMY,

With Observations Concerning the Causes of Stone in the Bladder, and its Geographical Distribution in the United States. Delivered November, 1877, at Jefferson Medical College Hospital.

BY S. D. GROSS, M.D., LL.D., D.C.L. OXON.,
Professor of Surgery in the Jefferson Medical College of Philadelphia.

(Reported by Frank Woodbury, M.D.)

GENTLEMEN: I desire to occupy your attention to-day with the case of a boy who has been brought to me on account of suffering in the bladder, strongly denotive of the existence of stone, for which I will now examine him.

After briefly adverting to the history of the case and the course of the disease, I shall examine into his present condition, and pass in rapid review over the principles that should guide you in your search for a vesical calculus, and in performing the lateral operation of lithotomy. In conclusion, I shall ask your attention to the consideration of some points in connection with the causes of stone, and the geographical distribution of calculous disorders in the United States.

The clinical history of this case may be very briefly summed up thus: Edwin K., 12 years of age, a native of Delaware, has suffered from urinary trouble as long as he can remember, having had attacks of difficult and painful micturition coming on at irregular periods, which are often so severe as to make him bend forward and grasp some near object

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for support, the urine meanwhile being voided in drops or suddenly stopped in its course; at other times it is passed with less inconvenience, but is followed by a constant aching pain in the bladder and surrounding parts. The prepuce is quite long, from frequent pulling to relieve the distress of dysuria. His appetite is good; the bowels are regular; and the general health is not seriously impaired; in short, all the functions, excepting the vesical, seem to be well performed, and an examination of the urine shows that there is no disease of the kidneys.

In sounding for stone, I usually prefer an instrument with a rather short curve, especially in young subjects, and it should never be so large as to distend the urethra. Palpable proof of the presence of a concretion is frequently obtained at the moment of introducing the sound, the stone being immediately encountered on entering the bladder; but in some cases, especially where the stone is small, it is much more difficult of detection, and may even successfully elude our efforts. The operation of sounding, although apparently simple and easily performed, is one not devoid of danger in unskilful hands; death having resulted in a number of cases from carelessness or improper interference. Certain principles should guide you in the operation, some of the more important of which I will briefly mention. In the first place, a patient should be to a certain extent prepared for the proceeding; the operation, for instance, should never be performed when he is fatigued by a long journey, or when suffering from a "fit" of the stone. Interference is, of course, improper when there is serious disease of the urethra, prostate gland, bladder, or kidneys. The examination should be conducted with the utmost gentleness, and should not be unduly protracted, as it might provoke violent cystitis or even fatal peritonitis.

During sounding the patient lies on his back, with the head and shoulders slightly elevated and the lower extremities somewhat flexed and separated, so as to relax the abdominal muscles. Adults are sometimes sounded in the erect posture; children never, except under particular circumstances. The bowels, if at all distended, should be emptied by a dose of oil or by an enema before the operation; but the urine should be retained for several hours, from three to four ounces being the average quantity required to enable us to perform the operation in a satisfactory manner. In a large quantity of fluid a small calculus might easily escape detection; or it might hide itself in a fold of mucous membrane, if an insufficient amount be present. Should the urine pass off prematurely, it may become necessary to inject a few ounces of tepid water through a catheter at the time of examination. In young children, in order to prevent crying and struggling, it is generally necessary to give an anæsthetic, but rarely in adults.

Before introducing the sound it should be carefully warmed and oiled, otherwise it may excite spasmodic contraction of the urethra, or shock the patient, and cause rigors and urethral fever. In case the stone is not encountered at once, the instrument must be carried successively through the different parts of the bladder, and particularly the post-prostatic portion or bas fond; a procedure which may be facilitated by introducing the left forefinger into the rectum and lifting up the posterior wall of the bladder. When the prostate is hypertrophied, this manipulation is particularly required. The metallic "click," caused by striking the sound against the stone, is characteristic; but this noise can only be elicited, as a rule, when the concretion is very hard and compact. In phosphatic calculi it is either very faint or entirely absent. By carrying the instrument around the calculus, information regarding its size may be obtained, and also as to whether it is loose or encysted, single or multiple. The composition of the stone may be inferred from the sound produced upon striking it, and by the character of its surface, whether smooth, irregular, dense, or friable. The calculus in the present case is one of considerable size, if we may judge from the rational signs and the testimony of the sound.

The question of treatment naturally

follows detection of the stone. Of the different internal remedies—alkalies by the mouth, or acids by the urethra—I will not stop to speak. Nor shall I have the time to discuss the operation of crushing the stone, or lithotrity, as it is improperly termed, which has been so frequently employed of late, especially in adults; I shall briefly mention the chief points to be observed in the performance of what is known as the lateral operation of cutting for stone, as this is the method which I prefer above all others for ordinary cases, and which I have most frequently performed. The operation, as practised at the present day, is as perfect as it is possible for such an operation to be, and in the hands of a skilful surgeon is capable of yielding the most gratifying results. With these remarks, I shall now proceed to its demonstration upon the patient whom I have just sounded: This precaution of previous sounding should always be adopted, and the presence of the stone fully established at the time of operation; otherwise a patient may be exposed to all the risks of cutting for stone, where no calculus exists, an awkward blunder which has, unfortunately, been committed more than once in the practice even of eminent surgeons.

Since the introduction of anæsthetics, the patient is no longer tied hand and foot as in former times. At all events, I myself long ago abandoned this practice, although our British brethren, I believe, still observe it, for what reason it would be difficult to say. The patient, being fully under the influence of chloroform, is brought down to the edge of the table, the buttocks extending a little beyond. The knees and thighs are flexed and the limbs separated by two assistants; the staff is introduced into the bladder and hooked up well under the pubic symphysis, the handle being slightly turned to the right so as to make the left side of the perineum rather prominent. The staff is deeply grooved on its convex surface to serve as a guide to the knife into the bladder. The staff-holder stands at the left side of the patient and raises the scrotum, keeping it out of the way of the operator. The person who is intrusted with this function should be well instructed in his duties, as a great deal of the success of the operation depends upon the manner in which he discharges them. It is impossible to lay too much stress upon this point.

The instruments needed in the operation—a long narrow-bladed scalpel, a probe-pointed bistoury, several pairs of forceps, a scoop, and a rubber syringe—are arranged upon a tray in the order in which they are needed by the side of the surgeon. The patient being at the edge of the table, the operator takes his position in front of him, either sitting on a low chair, or kneeling upon his left knee, as I am in the habit of doing. It is hardly necessary to say that the perineum, if covered with hair, should be well shaved, as a preliminary step to the operation. Everything being thus prepared, and care taken that the bladder is pretty well distended with urine, the surgeon introduces his forefinger into the rectum to assure himself of the position of the staff, and proceeds with his task. The external incision begins just at the left of the raphé of the perineum, about one inch and a quarter in front of the anus, and is carried obliquely downwards and outwards to a point a little more than midway between the verge of the anus and the tuberosity of the ischium. This incision only divides the skin and the cellulo-adipose tissues immediately beneath it, the depth depending upon the condition of the parts, some patients having a very deep perineum. The transverse artery of the perineum is generally divided in this stage of the operation, but it rarely requires to be ligatured, as the bleeding usually promptly ceases of its own accord. Placing the point of the left index finger in the upper part of the wound, the knife next cuts through the transverse perineal muscle, the triangular ligament, and the membranous portion of the urethra, the opening in the latter being made sufficiently large to admit the point of the index finger. Using this as a guide, the knife is inserted into the groove of the staff, and thence thrust on into the bladder, dividing in its course the neck of this organ and the left lobe of the prostate gland, in the direction of the external wound; that is, obliquely downwards and outwards. Care must be taken, in this step of the operation, to hold the knife somewhat horizontally, otherwise there will be great danger of wounding the rectum, which, as an additional security, should be gently pressed over towards the middle line, and held out of the way by the finger in the wound. The staff is withdrawn as soon as the bladder is fully opened.

If it is necessary that the bladder should contain urine when the patient is sounded, it is still more essential that the urine should be retained in operating for stone. If this precaution were neglected, the knife might easily transfix both walls of the viscus, and cause death from peritonitis. As soon as the bladder is opened, a gush of urine takes place, generally bringing the stone with it to the mouth of the wound. The staff is now withdrawn, and the calculus seized with the forceps, guided upon the finger lying in the bottom of the wound, and extracted pretty much in the same manner as the obstetrician removes the child's head in instrumental labour. If necessary, the wound may be enlarged with the probe-pointed bistoury, or the stone may be broken and extracted in pieces, taking great care not to injure the bladder and prostate gland. After extraction, the bladder should be examined for other calculi, and carefully washed out with tepid water to rid it of any debris and blood clots it may contain. If the calculus be soft or friable, it may be necessary to use the scoop for its removal.

In regard to the length of the incisions in this operation, a few words may be said. These must of course measurably depend upon the size of the calculus. For many years past, I have contented myself with comparatively small incisions, especially in children and young persons, in whom the parts are always very extensible, readily yielding under the pressure of the fingers, the forceps, and the stone during the extraction. In children, I invariably use the finger for enlarging the wound in the prostate gland and neck of the bladder, greatly preferring this procedure to making a large incision; and I can assure you that I have never, in any of my cases, met with any bad consequences from it. On the contrary, I am fully satisfied that it is, in every respect, the safest practice. In elderly subjects, this plan is of course inadmissible, owing to the greater density of the structures concerned in the deeper portions of the wound.

In performing this operation we necessarily divide, as already stated, the transverse perineal artery running along the posterior surface of the transverse muscle; but it rarely requires a ligature except when enlarged by prolonged vesical irritation. When the incision is carried too high up, the artery of the bulb may be opened; a mishap which is sure to be followed by a copious and troublesome hemorrhage, very difficult to arrest, owing to the great depth at which the vessel is situated.

The pudic artery in its normal situation under the ramus of the ischium, is said to be sometimes wounded; but I have never seen this accident, although cases are reported, among others, one by Dr. Physick, who devised a pair of forceps for its ligation. Most of such accidents have been caused by the use of the gorget or lithôtome caché. When the knife is employed the vessel is in no danger.

A great deal has been said about the division of the prostate gland in this operation leading to the formation of abscess from infiltration of urine. However this may be, I am certain that, in the great majority of cases, this gland is divided to its full extent in lateral lithotomy. Indeed, how could it be otherwise? I know I have myself divided it in most of my cases, but have never witnessed urinary infiltration; chiefly because the effused blood and lymph effectually seal the surfaces of the wound so that the urine cannot, under ordinary circumstances, force its way into the connective tissues.

When oozing of blood is excessive after the operation, it sometimes becomes necessary to plug the wound. For this purpose we may use Dupuytren's tube and chemise, or a female catheter, to which is attached a circular piece of linen, introduced into the bladder and packed lightly with lint. Or the wound may be temporarily plugged with ice, a soft sponge, or a compress wet with Monsel's solution or some other styptic.

To relieve the pain and spasm consequent upon this operation, my invariable rule is to give the patient at once, as soon as he is over the immediate effects of the anæsthetic, a full dose of morphia hypodermically, taking care afterwards to repeat the remedy once or twice in the twenty-four hours, according to the amount of suffering.

In my earlier operations, following the practice of Liston and others, I fastened a tube in the bladder to conduct off the urine; but I soon became satisfied that the procedure was bad on account of its tendency to provoke irritation and spasm, and I therefore long ago abandoned it.

The quantity of blood lost in the operation just performed hardly amounts to a few tablespoonfuls. The boy will now be placed in his bed upon a draw sheet spread over a piece of soft oil-cloth with the perfect freedom of his limbs and without any application to the wound. The urine after it shall have accumulated to the extent of a few ounces will make an effort to escape by the wound, and in doing this it will be sure to cause more or less pain and spasm, owing to the difficulty which it is obliged to encounter from the clots which plug up the abnormal passage. After these clots have been washed away the flow will be more easy, and will so continue for the first twenty-four or thirty-six hours, when, in consequence of the swollen condition of the parts, it will be discharged by the urethra, accompanied with more or less distress, at least for some time. Gradually, as the swelling subsides, the urine will again flow by the wound until final closure is effected. Great attention must be paid to cleanliness throughout the treatment; the draw sheet must be frequently changed, and no means spared to make the patient comfortable.

The patient's diet for the first twenty-four hours must be of the most simple kind; fever and pain must be relieved with tincture of aconite and diaphoretic anodynes; and the bowels, unless contra-indications arise, must not be disturbed under six or seven days. If much blood has been lost or the health was much broken prior to the operation, a milk diet, either alone or in the form of punch, will be the most suitable, aided by beef-essence, eggs, and quinia or quinia and iron. As convalescence advances, solid food is allowed. The bowels, if need be, are relieved by enema, castor-oil, or Rochelle salt, especially if they are distended with gas; but all active purgation is scrupulously avoided. Some of my patients have gone for upwards of a fortnight without an alvine evacuation. If the bowels are thoroughly moved, as they always should be, before the operation, there will be little need of laxatives, much less of cathartics.

The calculus after removal was found to weigh nearly one ounce and three quarters; it was of the uric acid variety, and was the largest stone of the kind that I ever removed from a child at this age. Uric or lithic acid concretions are the most numerous, and furnish probably about two-fifths of all the cases, the others being, in the order of frequency, uro-ammoniac, generally observed in children, oxalic, phosphatic or bone earth, ammoniaco-magnesian or triple phosphate, fusible, a combination of bone earth and triple phosphate—cystic, xanthic, fibrinous, and urostealith. These are often discharged while they are quite small.

Among the contra-indications to the operation may be prominently mentioned diabetes, Bright's disease, phthisis and the existence of the hemorrhagic diathesis. which, if previously recognized, would debar any prudent surgeon from exposing his patient to the risk of lithotomy. It is, however, worthy of remembrance that occasionally an apparently desperate case is followed by the most prompt recovery; and it is for this reason that I seldom refuse to operate under such circumstances, believing that a patient is always entitled to the benefit of a chance, however remote or unpromising. A man labouring under severe suffering from stone in the bladder is very much in the condition of one labouring under serious disease of the knee or ankle joint, attended with great wasting of the vital powers. If, in such a case, the offending part be removed, the patient at once becomes comfortable, and begins to improve in health and strength; and so with a person worn out by vesical suffering. The moment the stone is removed, and the bladder is placed at rest, the unfavourable symptoms often vanish like magic. I have little respect for a lithotomist who selects his cases, and rejects all the bad or unpromising ones; or, in other words, who is unwilling to incur some risk as it regards his reputation as an operator.

The component elements of a calculus are found to be, in general terms, certain insoluble, inorganic constituents united into a mass by a small amount of some allotropic condition of albumen probably derived from the mucus of the vesical secretion, and epithelial scales. This sabulous material is, as a rule, one of the salts of the normal urine precipitated by some abnormal local condition. A stone may be simply composed of a single substance, or may be formed by successive or alternate layers of the different salts, forming concentric rings of deposit. As a general rule the simple or homogeneous concretions are small, the larger ones being mixed or compound in their structure. Regarding the causes of stone in the bladder, we are yet in the dark. Many have been suggested, but the relation of cause and effect has not been clearly established for any of them. It is but reasonable to suppose from the complex constitution of the urinary secretion and the relation that it bears to the condition of the system, its composition constantly changing, and closely connected with the processes of waste and repair and the functions of nutrition, that the presence of certain ingredients in abnormal proportion might be brought about by a variety of circumstances, and that stone in the bladder may depend upon a multitude of causes rather than upon any isolated source.

The circumstances determining the formation of a calculus may be considered under two heads — 1st. The immediate local or proximate causes. 2d. The remote, general, or predisposing causes.

Briefly reviewing the local or immediate causes, we find them to consist in the presence of foreign bodies in the bladder itself, and they may be either congenital or acquired. A child may be born with a vesical calculus, or the concretion may form around the contents of a dermoid cyst, or a tuft of hair. The acquired nuclei are either intrinsic or extrinsic in their origin. Those arising from internal sources may consist of nephritic calculi, an exfoliated sequester from necrosis of a pelvic bone discharged into the bladder, or small clots of blood, mucus, epithelium, pus, or fibrin. The extrinsic nucleus, or that introduced from without, either by accident or design, may consist of the greatest variety of articles that can be imagined.

Allied to the proximate causes, but acting among those favoring the occurrence of stone rather than directly determining its presence, are certain local disorders of the genito-urinary apparatus, such as stricture of the urethra, diseased prostate, cystitis, or kidney-disorders. In general terms it may be stated that any cause interfering with the complete evacuation of the bladder favours the formation of stone, both by retaining small renal calculi that would otherwise be expelled from the vesical cavity, and, indirectly, by retaining urine which produces cystitis by its decomposition and irritating deposits.

Among the remote or predisposing causes of this malady may be mentioned disorders of the nervous system, and especially injury to the spine. Disturbed or abnormal mental states have been thought to favour certain deposits that would lead to the formation of calculous concretions. This is unquestionably true of certain impaired conditions of health, especially when accompanied by deficient elimination of waste by the emunctories, as the skin, liver, or kidneys. This may explain the influence of individual diseases, such as inflammation, dyspepsia, constipation, cirrhosis of the liver, and others, that have been named as active agents in producing this affection. Malaria has also been cited as the cause of this as of so many other complaints. The rheumatic and arthritic diatheses, for obvious reasons, are more apt to be accompanied by stone in the bladder than the tubercular or strumous, although phosphatic deposits are sometimes seen in tubercular patients.

The period of life, or the age of the patient, has less influence upon the formation of stone than is generally supposed. Calculus occurs at all stages of physical development, although, probably, most frequently in early life. The relation of occupation is an interesting one as bearing upon the influence of sedentary or active habits upon the formation of stone. Soldiers and sailors seem to enjoy almost an immunity from this disease; on the other hand, farmers and labourers furnish a large number of cases. But this may be connected with the causes next to be considered. Occupations requiring exposure to cold and wet are said to favour this affection, but this observation is not positively established. Station in life is a much more prominent factor in calculous disorders; it is a familiar fact that the poor are much more prone to the development of stone in the bladder than the rich. This may be due to poor diet, intemperance, imperfect clothing, disturbing the functions of the skin, and to unhealthy surroundings generally.

Although heredity is supposed to influence the development of this disease, I have not met with any examples of it in my own experience. It is asserted, however, by Oppenheim,[1] that it is hereditary in certain districts of Turkey, particularly Macedonia, Epirus, and Thessaly.

Women are much less liable to suffer from stone in the bladder than men, owing to the differences in the structure and size of the urethra, which, in consequence of its shortness and dilatability in the female, enables her to expel almost any concretion with the urine the moment it descends from the kidneys. In males, on the contrary, even the smallest concretion generally remains imprisoned behind the prostate gland.

Race, also, materially affects the liability to calculous disorders. Negroes are much less subject than whites, but in what proportion has not been ascertained. The Chinese and the Hindoos, on the other hand, as well as the natives of lower Egypt and of Turkey, seem to be especially liable to such affections. The lower classes in Russia and Denmark are much more disposed to the disease than the same classes in Sweden and Norway; and, while it is rare in some parts of the German empire, it is comparatively frequent in Hungary, France, and Holland.

It is reasonable to suppose that diet might have some effect upon the development of calculus, as highly nitrogenized articles of food, consisting principally of the different kinds of meat, would furnish an excess of urates. On the other hand, it is well known that the urine of herbivorous animals is markedly alkaline, a condition which, if it existed for any length of time in the human subject, would undoubtedly favour the deposit of those earthy phosphates that are ordinarily kept in solution in the urinary secretion by the acid phosphate of soda, assisted by free acids. An exclusive diet of fish or cereals might also yield a disproportionate amount of phosphates; other faults in diet would produce disordered digestion and imperfect assimilation, with its consequences already considered. But, in point of fact, the corn-bread diet of the South, which has been thought to be a cause of stone, does not warrant this opinion when closely inquired into. Dr. De Roos attributes the frequency of lithiasis in Russian children, among other causes, to the consumption of large quantities of farinaceous food, potatoes and cakes. The drink has also been blamed for this trouble. The use of hard water, or water containing large quantities of the earthy salts, for drinking purposes, has been thought to be an active cause; but some sections of country are perfectly free from stone, where this is the only water obtainable. Malt liquors and cider are still believed to favour the formation of stone, although no sufficiently definite facts have as yet been obtained to warrant this opinion. Wines, on the contrary, furnishing bitartrate of potassa, are highly praised for the prevention of stone; and the Rhenish provinces, where these wines are manufactured and freely drunk, are reputed to enjoy a remarkable exemption from the disease.

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[1] Uber den Zustand der Heilkunde in der Europäuschen und Asiatischen Turkei, p. 121. Hamburg, 1833.

Climate certainly has more or less effect as a predisposing cause, especially where the variations of barometric pressure and atmospheric humidity are excessive, irregular, and sudden. Although the data are very deficient, and scarcely justify the expression of a positive opinion, yet it is evident that, while such conditions interfere with the eliminative functions of the skin and throw more nitrogenous waste upon the kidneys for vicarious excretion, they also favour the production of inflammatory disorders and other disturbed states of the system that have already been referred to as efficient causes of the formation of stone. Temperature and its vicissitudes, as a general cause, are closely associated with the preceding and also with certain local influences that may most conveniently be reviewed under the appropriate geographical divisions in our concluding remarks. In very cold, as well as in tropical, regions stone is very rare. Some years ago I entered into an extensive correspondence with the most prominent surgeons in the different sections of the United States and other countries to determine, if possible, the geographical distribution of stone in the bladder, with a view of investigating its causes. The results of this study were placed as an appendix to the second edition of my work on *Diseases of the Urinary Organs*, published in 1854, this being the only attempt of the kind to place the subject in a tangible form that had been made on this continent up to that time. The conclusions then attained have not been changed by subsequent information and experience. The great stone-producing regions are Kentucky, Tennessee, Virginia, Ohio, northern Alabama, and, to a certain extent, Missouri. Pennsylvania furnishes a fair number, although relatively fewer cases, while New England is remarkably exempt. There is no essential difference in the climate, soil, and productions of Kentucky and Indiana, or in the food, drink, occupation, and modes of life of their inhabitants, yet in the one stone in the bladder is very frequent, and in the other, very rare. Illinois also furnishes very few cases. Maine, New Hampshire, and Vermont are almost entirely free from this disease, and indeed Massachusetts might well be included in the statement, so few are the cases reported. In Connecticut and Rhode Island the disease rarely originates. Coming further south we find that New York, especially the western part of the State, furnishes a larger proportion, while in New Jersey the disorder is rarely met with; and there is good reason for believing that in Maryland it is scarcely more frequent. North and South Carolina produce very few cases. No data are in my possession concerning Florida, but it is probably governed by the same conditions as southern Alabama, where stone is comparatively rare. Louisiana, Mississippi, and Arkansas are comparatively free, while Missouri furnishes a fair proportion of cases. The disease, from all I can learn, is quite uncommon in Michigan, Iowa, Wisconsin, and the far West. California has such a changing population that the development of stone in a native would be a rare occurrence. Some few cases of operation have occurred, but most of these were probably upon persons of foreign birth. The Chinese population should furnish a good proportion of cases, as they have largly immigrated from the vicinity of Canton, where, judging from the experience of my friend Dr. Kerr and others, stone and calculous disorders are of very frequent occurrence.

In reviewing the geographical distribution of calculous diseases, we find that districts in which soft water is habitually used as drink are by no means exempt from this class of diseases, although limestone regions furnish by far the greatest number of cases. No immunity, certainly, is afforded by living in a freestone region. The food of districts similarly situated but not similarly afflicted, is exactly the same, as well as the climatic conditions. Why such differences should exist has not been determined. To my mind it is certain that no one cause has produced them, but the problem is a complex one, no doubt varying in its factors in each individual case. As long as we remain unable in each single case to state positively the laws of the formation of stone in the bladder, we shall be at loss for any philosophical groundwork upon which to base a rational hypothesis concerning the general causes of calculous disorders.

The brief suggestions just reviewed may serve as nuclei for future observation, and lead ultimately to the further elucidation of the obscure but most interesting subject of the etiology of stone in the bladder.

In regard to the lad, the subject of the operation described in this lecture, it is proper to state that he went home at the expiration of the fourth week, perfectly well, with the wound completely healed. Nearly all the urine passed off by the natural channel by the end of the fourteenth day. He was requested to live for some time upon a simple diet, consisting mainly of eggs, fish, oysters, stale bread, and the lighter kinds of vegetables, with the free use of milk, until the tendency to irritability of the bladder, that always follows the operation, should finally subside and complete the cure.

HOSPITAL NOTES AND GLEANINGS.

A Severe Case of Acute Rheumatism complicated by Pericarditis and Broncho-pneumonia relieved at once, when the patient was apparently dying, by Salicylate of Soda, after failure of a fair trial of the Alkaline Treatment.

Dr. Whipham reports (*Lancet*, Oct. 13, 1877) this case, which was under his care at St. George's Hospital. Apart from the severity of the rheumatic attack, it is specially interesting as an illustration, 1st, of the now universally acknowledged beneficial effects of salicylic acid in the treatment of acute rheumatism; 2d, of the fact that the administration of the drug does not appear to be contra-indicated in cases in which extreme prostration has resulted from a prolonged continuance of the rheumatic symptoms. The subject of the above notes, when admitted, was excessively weak and in acute pain, and with a view of relieving the articular pain full doses of alkali were ordered, and at the same time two grains of quinine. That the bowels were purged was duly taken into consideration, and it was determined, in spite of the fact that alkalies in such full doses not unfrequently cause diarrhœa, to administer bicarbonate of potash, in the hope that the acute pain, which was by far the more prominent symptom, might be relieved. The urine, from having been turbid with urates, became, in five days, alkaline, but on the sixth day the patient was so extremely prostrated that a stimulant and tonic mixture was given. The diarrhœa continued, but was stopped on the eighth day by two full doses of bismuth. The pain in the joints was unrelieved. Little or no improvement took place, in spite of various remedies, for the next three weeks, and the question as to the advisability of administering salicylic acid was often debated and as often discarded, in consequence of the patient's great weakness and depression. His temperature had, however, as shown by the notes, come gradually down from 102° to 99°. On January 11, 1877, four weeks after his admission, he was ordered quinine, iron, and ether, with alcohol (brandy and port-wine), which he had been taking since admission; and three days later symptoms of broncho-pneumonia of the base of the left lung become manifest, and from January 15th to January 23d he took different mixtures, such as ammonia, iodide of potassium and bark, perchloride of iron, phosphoric acid, and strychnia. On January 26th he experienced a severe recurrence of his rheumatic pains, which had latterly been to some extent relieved, and on the following day, in spite of weakness so extreme that the boy's life was despaired of, it was determined, as a last resource, to try the effect of salicylic acid, and he was ordered salicylate of soda in scruple doses every two hours, and to continue his brandy. The result of this change of treatment was almost immediate; and the rapidity of the boy's improvement fairly astonished all who had watched the case. On January 25th all hopes of his recovery had been abandoned, and the salicylate of soda was commenced on the 26th. On the 27th he was much easier and stronger, and three days later he was in "no pain, feels much better, no depression." Three days after that (February 2d) he was allowed to get up.

During the months of February and March he suffered from slight pains in various joints, which were always relieved by the drug, and he eventually left Atkinson Morley's Convalescent Hospital on March 28th, comparatively strong and in good health.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Is the Human Eye changing its Form, and becoming Near-sighted, under the Influence of Modern Education?—Dr. E. G. Loring recently read an interesting paper on this subject before the New York County Medical Society (*New York Med. Journ.*, Dec. 1877). He said that hereditary influence was an important element in the production of myopia, and, although statistics did not strongly indorse that view, he still held that legendary information should receive much credence. In regard to the influence of modern education, it was found that a larger proportion of those living in cities were near-sighted than those in country districts; and, moreover, in those cities where intellectual pursuits were greatest, the largest number of myopes were found. In savage nations near-sightedness was very infrequent, and it would seem, in some respects, that it was a result of education. While the intellectual classes in Germany showed a large proportion of myopia, it was not so found in those artisans who used their eyes on fine objects, as watch-makers and wood-engravers. In England, where there has always been great intellectual activity, by no means as large a ratio of near-sightedness had been detected as in Germany, and it became necessary to seek for other factors to explain the prevalence of myopia. Impaired nourishment, imperfect ventilation, together with a sedentary life, had a marked tendency in producing laxity of the tissues in general, including of necessity the coats of the eyeball; and, with the tension which resulted from close application of the sight, there was a great probability of lengthening of the eye, or myopia, resulting. In New York the German children were found more often near-sighted than those of other nationalities. Dr. Loring said that undoubtedly myopia was hereditary, but that in all probability it could under no circumstances be developed; but he did not believe that of necessity it must increase in a nation engaged in literary pursuits. In the United States the normal eye predominated, and he thought it was due to the fact that the young were more in the habit of indulging in out-door sports than in Germany. The same was true of England. From a careful analysis of the myopic cases, it was found that between the ages of ten and fifteen the majority developed; or, in other words, at that time the tissues of the globe were more readily affected by strain of the muscles of the eye. It could be easily understood, under such an hypothesis, that the industrial classes were so little liable to near-sightedness, for they seldom reached the practice of the more intricate branches of their trade before their eighteenth year. In conclusion, Dr. Loring was of the opinion that, under proper precautions, the normal eye could be continued indefinitely. If children were not allowed to apply themselves too closely to their studies between their eighth and sixteenth years, and were, moreover, allowed the proper amount of out-door exercise, not much danger need be dreaded. It was important also to have the schools perfectly ventilated, and other hygienic conditions made as perfect as possible.

Skunk Cabbage in Chorea.—Dr. Horatio C. Wood has been trying skunk cabbage, or dracontium, in the treatment of chorea. "I am using," he says, "a saturated tincture of the rhizoma, and am giving from eighty to ninety drops three times a day. I began with sixty drops thrice daily. If you determine ever to make use of this drug you must not get your supply of it at the drug stores. You will find plenty of the fresh rhizomas for sale about the markets. The best time to lay in a stock of dracontium is in the fall, and it should be at once made up into the form of a tincture. The root must not be dried before using. The effects of the skunk cabbage are probably due to some volatile principle which it contains. This woman has been taking dracontium for a short time, and is already able to notice a marked improvement of her symptoms. She has less of the jerking movements, and feels altogether vastly better."—*Med. Record*, Dec. 15, 1877.

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Carbolic Acid in Eye Surgery.—Dr. Julian J. Chisolm recommends (*Va. Med. Monthly*, Dec. 1877), in cases of warts upon the eyelids, episcleral thickening, epithelial growths upon the surface of the cornea, and granulated lids, carbolic acid applications, both as an efficient agent in correcting the pathological condition, and an innocent one, inducing no injury of any kind to the delicate tissues of so sensitive an organ. In marginal ulcers of the hair follicles, he would expect the same beneficial results that so constantly follow the application of carbolic acid to cutaneous ulcers.

In the treatment of catarrhal ophthalmia with muco-purulent discharges from the conjunctival surface, he has seen no marked benefit ensue from combining carbolic acid with the usual astringent remedies.

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Harvard Medical School.—This school now requires all candidates for admission who do not possess degrees in letters or science from a recognized college, to pass a preliminary examination. We are glad to learn that the size of the class is considered as encouraging, and the falling off in the number of first-year students is by no means as large as was anticipated.

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Boston Medical Library Association.—The late Dr. Edward H. Clarke has left his valuable medical library to this Association. We are glad to learn that the collection of the Library Association has greatly increased, and that it is fast outgrowing its present quarters.

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Obituary Record. — In Boston, November 30, 1877, aged 57, Edward H. Clarke, M.D., late Professor of Materia Medica in Harvard College.

The death of Edward H. Clarke has left a gap in the ranks of New England's medical profession which will not easily be filled. Dr. Clarke held in Boston, for many years, the position of the favoured consultant. For a long while his local reputation as a teacher and a practitioner were unsupported by any very notable additions to medical literature. Of late years he won a wider fame by two little books[1] which dealt boldly and aggressively with the subject of the education of the two sexes. The matter of these essays gave rise to a sharp and prolonged discussion. An essay on the bromides, written in conjunction with Dr. Robert Amory; a *brochure* on Polypus of the Ear (1867); *A Century of American Medicine* and a few original articles and reviews contributed to the *American Journal of the Medical Sciences*, completes the short list of his medical papers. At the time of his death Dr. Clarke was busy with a book on apparitions, but nothing that he has left us fully explains the reputation of this brilliant and successful physician. The man was, in the estimate of all who knew him well, far greater than any work he has left behind him. In early life he overtaxed his brain, and was never afterwards able to endure prolonged study, so that he probably found the practice of his profession, with teaching, to be all that he could compass. The real distinction was in his position as a practical physician. Beyond this he was a man of wide culture, a charming companion, a ready speaker, and, as his clear and energetic style shows, a master of wholesome, vigorous, and simple English. A few years ago he was attacked with cancer of the rectum, and was suddenly forced to give up his medical work. The years of torment which followed were marvellous to those who, knowing what he suffered, saw his uncomplaining sweetness of life, his thought of and for others, his interest in and sympathy with all forms of science. The calmness with which he noted and discussed the character and progress of his malady, was most remarkable. Nor did this noble fortitude give way when, in the midst of his terrible struggle with ever-increasing pain, his wife suddenly fell a victim to acute disease. It is to be hoped that the work on which he was engaged may find a fitting editor, and that we may thus get from his labours all that it is possible to get.

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[1] Sex in Education. The Building of a Brain.

FOREIGN INTELLIGENCE.

Treatment of Hæmoptysis from Lung Cavities.—Dr. R. Douglas Powell, Physician to Brompton Hospital for consumption, makes the following remarks on the treatment of hemorrhage from phthisical cavities (*Lancet*, Dec. 1, 1877).

The treatment is such as would be dictated by common sense. The most absolute rest in bed is imperative. Beware of the brandy-bottle. The first thing the friends of the patient naturally do when they find him faint from hemorrhage is to give him brandy. But this moment of faintness is just the period at which there is the opportunity for the hemorrhage to become staunched by the formation of a coagulum, and so long as the pulse does not absolutely fail, we should withhold stimulants, and avoid them throughout the treatment of the case. We can scarcely expect drugs to do much in such cases as these. Ergot in full doses and turpentine have been found most useful at this hospital. The momentary application of an ice-bag to the chest or between the shoulders appears sometimes to be useful. When the shock is great, opium will best relieve it. After a day or two, if the exhaustion and anæmia be great, an astringent form of iron is often of great value, as the iron alum or the pernitrate of iron, but the effect of these remedies must be closely watched. In cases in which there is a tendency to recurrence of the hæmoptysis, such patients usually making blood fast, the diet should be carefully restricted, principally to fish and farinaceous food, without stimulants.

Phenicated Camphor in Diphtheria.—Dr. Souley called the attention of the Société de Thérapeutique (*Gaz. Hebd.*, Nov. 23) to the great utility of this substance as a local application in those cases of diphtheria in which the deposits of false membranes constitute the initial and chief phenomenon—the danger arising from the steady and rapid propagation of these membranes, or the ulterior intoxication of the economy. Under the contact of the phenicated camphor the pseudo-membrane seems to lose its vitality, without that irritation of surrounding parts being produced, whether of the skin or mucous membrane, which is almost always caused by the various solid or liquid topical applications now in use. The solution employed by Dr. Souley is formed by dissolving powdered camphor in crystallized carbolic acid previously dissolved in alcohol (nine parts of the acid and one of alcohol), and which may be employed either in its pure state, or mixed with equal parts of sweet almond oil. He related four cases in support of this mode of treatment.—*Med. Times and Gaz.*, Dec. 8, 1877.

Lactic Acid as a Hypnotic.—Lactic acid, originally discovered by Scheele in fermented milk, is one of the products of the metamorphosis of tissue in muscle, and was suggested by Preyer as an hypnotic on theoretical grounds. Dr. Mendel has lately carried the theory into practice, giving from one to two drachms for a dose in the form of lemonade sweetened with sugar, and diluted, or in double those doses as an enema, neutralized with the same quantity of carbonate of soda, since in its pure state it acts as an irritant to the intestine. It is said to act best when conditions preventing sleep are of a mental nature, whilst it is inoperative if the sleeplessness is occasioned by pain.—*Lancet*, Dec. 8, 1877.

Therapeutic Action of Balsam of Peru.—Dr. E. Wiss, at a late meeting of the Medical Society of Berlin, called attention to the long-known, but lately somewhat neglected, value of the balsam of Peru in wounds, and in some other affections. He states that in all cases of cuts and lacerations, if the balsam be applied to the part injured, a momentary smart is felt, which is immediately followed by relief of the pain previously experienced, and the wound will be found to heal up with great rapidity, without suppuration, or indeed any signs of inflammation. The power of the balsam to prevent suppuration led him to employ it in chronic catarrh, as had been long ago recommended by various authors, and he mentions several cases in which the administration of it in the form of an emulsion with the yelk of egg, in the proportion of four parts of balsam to 120 of yelk, a teaspoonful being given every second hour, proved of the greatest service.—*Lancet*, Oct. 27, 1877.

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Feeding per Rectum.—An article appears in *Deutsche Zeitschrift für Praktische Medicin* (No. 44, 1877), in which Dr. Kauffmann draws attention to the excellent results he has obtained from the plan of feeding the patients with pancreas and meat in cases of persistent and incurable intestinal obstruction. He states that he has had nine patients in the Kölner Bürger Hospital, seven of whom were suffering from cancer of the œsophagus, one from cancer of the pylorus, and one from chronic ulcer of the stomach. In all of these a cleansing enema was administered in the morning, followed by the introduction into the rectum of a mixture of a pound of finely divided beef and one-third of a pound of finely minced pancreas, the whole being freed from fat and connective tissue. Half of this quantity was used at noon and half at 6 P. M. The results were excellent; a solid, well-formed, healthy evacuation was discharged every day. The patients were able to walk about, and lived for nine or more months.—*Lancet*, Dec. 8, 1877.

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Administration of Salicylic Acid.—Dr. Gueneau de Mussy recommends the administration of salicylic acid by dissolving it in a syrup of gum by the aid of ten times its weight of brandy, and adding to it a little lemon juice.

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Treatment of Epilepsy by Bromide of Zinc.—Experiments have been going on for some time in M. Charcot's wards at the Salpêtrière Hospital with bromide of zinc as a remedy for epilepsy. It can be administered either in the form of pills or as a syrup. The pills contain each three-quarters of a grain of bromide of zinc. Commencing with one pill daily, the dose may be increased to twenty-five grains, increasing the quantity of bromide contained in each pill. The drug can be given in syrup according to the following formula: Bromide of zinc, 15 *grammes;* syrup of bitter orange-peel, 150 *grammes;* four, five, or six teaspoonfuls to be taken in the course of the day. The results obtained from the administration of these pills have been satisfactory.—*British Med. Journal*, Nov. 24, 1877.

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A Sign of Hæmoptysis.—M. Constantine Paul observed (*Gaz. Hebd.*, Oct. 19), at the Société de Thérapeutique, that a sure prognostic sign of hæmoptysis is found in the recurrent pulse. If while the finger compresses the artery at the wrist, a pulsation is found in the hand, we may feel certain that the patient will spit blood. During the last ten years that he has paid attention to the point, he has come to regard this sign as certain.—*Med. Times and Gaz.*, Oct. 27, 1877.

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The Poison of Typhoid Fever Conveyed by Water.—Local epidemics of typhoid caused by the evacuations of a patient gaining access to drinking water are well worthy of being placed on record. A recent number of the *Berliner Klinische Wochenschrift* contains an account of five cases in which infected water was the undoubted medium of communication. A miller, living on the bank of a small stream, was attacked by typhoid. His excreta were thrown daily into a small pond, which was connected with the stream by a ditch. The man recovered, but, seven weeks after his attack, his brother, who alone had nursed him, fell ill with serious symptoms of typhoid. The discharges from the bowels were very profuse, and were, as before, thrown into the pond. A few days afterwards four workmen, who were employed at a forge about a mile distant, were also attacked by typhoid, and the medical attendant, anxious to discover the source of the mischief, found that all these men obtained their drinking water from the stream in question, there being no well available. Another case also occurred, the patient being a farm labourer who worked in a meadow near the forge, and who also drank the water from the stream. No case of typhoid had been known to occur in the neighbourhood for a very long time previously, and all the circumstances were in favour of the supposition that the disease had been transmitted through the medium of the water. There was no evidence as to the source of infection in the case of the first patient. The period of incubation was extraordinarily long, particularly in the case of the brother. The history of this small epidemic tends to support Dr. W. Budd's view, that a specific agent must be present for the production of typhoid fever. Probably the water of the brook in question often contained more or less ordinary fecal matter. The lesson to be drawn is that the excreta of typhoid patients should be completely disinfected, and, where possible, as in country places, should be deeply buried in spots far removed from any source of water supply.—*Med. Examiner*, Nov. 29, 1877.

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The Epidermis of the Genito-crural Fold and its vicinity as a breeding-place for the Oxyuris Vermicularis.—Under the above title Dr. Michelson, of Königsberg (*Berl. Klin. Wochenschrift*, No. 33, 1877), describes the case of a healthy boy of thirteen, who was brought to him with eczema of the scrotum and the neighbouring parts of the thighs, and in which he found numerous eggs of the *Oxyuris vermicularis* embedded in the affected epidermis. The perineal region, and the back and lower part of the scrotum were free. The itching is so severe as to prevent sleep. The question was, from whence had come the female oxyuris which had laid the eggs? On inquiry, the boy stated that he had suffered from rectal worms as long as he could remember; but as the oxyuris requires a skin covered with some glutinous material for it to travel on, and quickly dies on a dry epidermis, it was unlikely that the worms had crawled directly to the affected part along the perineum. It seemed most probable that they were carried on some fecal matter which adhered to the boy's shirt, the front border of which he had a trick of tucking back between his legs. An attempt was made by means of warm compresses to see whether the ova could be brought to maturity in this position, as Leuckart asserts that the embryos require the action of gastric juice in order to set them free. The experiment failed. The eczema was cured in a few days by warm baths, and a powder of one part salicylic acid and five parts starch.—*Med. Times and Gaz.*, Sept. 15, 1877.

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Detection of Particles of Hepatic Structure in Abscess of Liver.—Dr. Samuel Fenwick recommends (*Lancet*, Nov. 17, 1877) a careful examination of the discharge of a hepatic abscess, however produced, as the amount of hepatic or pulmonary structures that may be present is the best indication of the gravity of the case. The same method of procedure should also be extended to the examination of the discharge from other organs, and thus not only may the exact structure from which the pus proceeds be detected, but the rate at which the ulceration is progressing may be ascertained, and thereby a more accurate prognosis formed.

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Death from Chloroform.—The *Lancet* (Dec. 8, 1877) reports a case of death during the inhalation of chloroform preparatory to undergoing an operation, which occurred in South Wales.

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"*Survival of the Fittest.*"—In a notice, with this heading, of the completion of the fiftieth year of publication of the *American Journal of the Medical Sciences* under its existing title, the London *Medical Times and Gazette* (Nov. 24, 1877) says:—

"This is universally acknowledged as the leading American Journal, and has been conducted by Dr. Hays alone until 1869, when his son was associated with him. We quite agree with the critic that this Journal is second to none in the language, and cheerfully accord to it the first place, for nowhere shall we find more able and more impartial criticism, and nowhere such a repertory of able original articles. Indeed, now that the *British and Foreign Medico-Chirurgical Review* has terminated its remarkable career, the American Journal stands without a rival. The latter journal, which, under Dr. Forbes's masterly guidance, inaugurated a revolution in medical criticism, was commenced as the *British and Foreign Medical Review* in 1836, and was incorporated in 1843 with the *Medico-Chirurgical Review* (whence its compound name of *British and Foreign Medico-Chirurgical Review*), a journal of much older standing, founded by Dr. James Johnson in 1816, and for many years almost solely conducted by him. The *Boston Journal* assumed its present name in 1828, being formed by the fusion of two journals, one of which dated back to 1812. The writer of the article is in error in assigning an early date to the *Edinburgh Medical Journal*, commencing, as it did, with that title only in 1855, and being a continuation of the *Monthly Journal of Medical Science*, commenced in 1841. He has confounded it with the *Edinburgh Medical and Surgical Journal*, established in 1805, and terminating a career that, without exaggeration, may be designated as famous, in 1854[1] The *London Medical Gazette*, founded in 1828,[2] was in 1852 incorporated with the *Medical Times*, founded in 1839, constituting the journal which the reader has now before him. The *Lancet* was established in 1823; but the *British Medical Journal*, originally founded by Dr. Hennis Green as the *Provincial Medical and Surgical Journal*, only dates back as far as 1841. The *Dublin Medical Journal*, published first on alternate months in 1832, then as a quarterly, and now as a monthly, has always been a journal of which any country might be proud. Among existing Parisian medical journals, the *Gazette Médicale* dates from 1830, the *Gazette des Hôpitaux* from 1828, and the *Union Médicale* only from 1847. The *Révue Médicale*, formerly a monthly, and now a weekly journal, was first published in 1820; and the *Bulletin de Thérapeutique*, a fortnightly one, in 1837.[1] The best French medical periodical, the *Archives Générales de Médecine*, was commenced in 1823. In Italy the *Annali Universali di Medicina* has been published uninterruptedly from 1816 to the present time. The immense brood of German medical periodicals are of comparatively recent origin; but the celebrated year-books, so indispensable to all working at any subject, date from 1834 (*Schmidt's Jahrbücher*) and from 1841 (*Canstatt's* and now *Virchow's Jahresberichte*)."

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Circulating Surgical Instrument Association.—The *Lancet*, Oct. 13, 1877, announces the formation in London of a Circulating Surgical Instrument Association. By an annual subscription of one guinea any medical practitioner may borrow, in good working order, any surgical instrument which may be required, either for operation or for the treatment of a case. This Association cannot fail to attract subscribers; indeed, its necessity being so manifest, the wonder is that no enterprising manufacturer has not hit upon the idea before.

—

OBITUARY RECORD.—On the 25th of September, aged 62, Dr. C. A. WUNDERLICH, Professor in the University of Leipzig. Dr. Wunderlich was the author of a *Handbook of Pathology and Therapeutics*, a *History of Medicine*, a treatise on the *Pathological Physiology of the Blood;* but the work by which he is best known is his classical book *On the Temperature in Disease.* His death is a loss to medical science as well as to the University of Leipzig.

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[1] We hope the Editor of the *Medical Times and Gazette* will pardon us for pointing out that, in his interesting sketch of medical journalism, the error on this point is his. The last number of the *Edinburgh Medical and Surgical Journal* (quarterly) was published April, 1855, and the first number of the *Edinburgh Medical Journal* appeared July, 1855, and having on its title-page "combining the Monthly Journal of Medicine and the Edinburgh Medical and Surgical Journal."

[2] December 8, 1827.

[1] This is probably a misprint for 1831.

[illegible]EW WORK ON THE EAR—Now Ready.

THE EAR;

ITS ANATOMY, PHYSIOLOGY, AND DISEASES.

A PRACTICAL TREATISE FOR THE USE OF MEDICAL STUDENTS AND PRACTITIONERS.

By CHARLES H. BURNETT, M.A., M.D.,
Aural Surgeon to the Presbyterian Hospital; Surgeon in Charge of the Infirmary for Diseases of the Ear, Philadelphia.

WITH EIGHTY-SEVEN ILLUSTRATIONS.

In one very handsome octavo volume, of 615 *pages: cloth,* $4 50; *leather,* $5 50.

Recent progress in the investigation of the structures of the ear, and advances made in the modes of treating its diseases, would seem to render desirable a new work in which all the resources of the most advanced science should be placed at the disposal of the practitioner. This it has been the aim of Dr. Burnett to accomplish, and the advantages which he has enjoyed in the special study of the subject are a guarantee that the result of his labors will prove of service to the profession at large as well as to the specialist in this department. A few notices from the medical press are appended.

This is a treatise for medical students and practitioners, covering a field that has only lately been deeply and properly cultivated. Its aim is to be comprehensive as to its subject, and so thorough and accurate in the diagnosis and treatment as adequately to meet the wants of the specialist as well as of the general practitioner. It is one of the most complete works on the ear that has come under our notice; and the division and subdivision of its contents into different parts representing those of the ear is well adapted to present explicitness in demonstrating the anatomy, physiology, and pathology of the separate parts of this organ. An elaborate review of this work would be impossible in the short space allotted therefor, as the whole treatise is so well written and contains so much that is new and interesting that extracts could not be made in length enough to do credit to the author. In short, every subject in relation to the ear is practically detailed in its anatomy, physiology, pathology, and treatment, and the whole is a great acquisition to the catalogue of text-books for our profession.—*Phila. Med. Times,* Dec 8, 1877.

As this is the most recent work on the ear, and also the best, we do not hesitate to recommend it to our readers, feeling convinced that a careful study of its contents will cause the early recognition of many apparently slight disorders, which, if not promptly and correctly treated, would ultimately lead to permanent deafness, and perhaps to death.—*Am. Supp. Obstet. Journ. Gt. Britain and Ireland,* Dec. 1877.

As the title of the work indicates, this volume treats of the anatomy and physiology of the ear, as well as of its diseases, and the author has taken special pains to make this difficult and complicated matter thoroughly clear and intelligible. The book is designed especially for the use of students and general practitioners, and places at their disposal much valuable material. Such a book as the present one, we think, has long been needed, and we may congratulate the author on his success in filling the gap. Both student and practitioner can study the work with a great deal of benefit. It is profusely and beautifully illustrated.—*Hospital Gazette,* Oct. 15, 1877.

The medical student and general practitioner have long felt the need of a book of this character on an organ so little understood and yet so important as the ear. The author has presented in the volume clearly but concisely the great advances which have been made of late years in otology and has indicated the direction in which further researches can be most profitably carried on. The work is divided into two parts. In Part I. the anatomy and physiology of the ear are minutely, yet explicitly, detailed in a manner not to be found in any of the ordinary text-books. In Part II. the diseases and treatment of the ear are fully and practically presented. To the medical student and general practitioner, this work is indispensable, and will not be found void of interest to the specialist.—*Maryland Med. Journal,* Nov. 1877.

Considerably more space than we can allow to it would be required to give a notice worthy of this admirable work. The author has become well known as an authority on the affections of the organ of hearing; and the volume which, after considerable preparation, he now offers to the medical profession, completely justifies his reputation. The number of references to the literature of the subject is very large, and correspondingly valuable.—*New Remedies,* Oct. 1877.

This text book is prepared by an author of great distinction in his specialty, both as a practitioner and a teacher. His right to this distinction is manifest from an examination of the work he now presents the profession. We are constrained to give the book a cordial recommendation.—*Va. Med. Monthly,* Oct. 1877.

The book is finely illustrated, well printed, provided with a good index, and is altogether a very good presentation of our present knowledge of aural medicine.—*St. Louis Clin. Record,* Dec. 1877.

There is probably no other book of the kind in the English language which contains so concise and yet so complete an account of the numerous diseases to which the ear is liable. We can safely predict that every intelligent medical man who takes the trouble to make himself familiar with the leading facts concerning this class of disease, as given by Dr. Burnett, will not only admit that the time thus employed was far from being wasted, but that the earnest labors of Otologists within the last few years have taken away the sting of reproach contained in the hackneyed phrase that "nothing can be got out of the ear but fees and wax."—*Canada Med. and Surg. Journal,* Nov. 1877.

The book is handsomely illustrated with eighty-seven cuts, and is divided into two parts: the first treats of the anatomy and physiology of the ear; the second, of the diseases of the ear and their treatment. The style of writing is simple, practical, and plain, the subject-matter very complete; and it will surprise the uninitiated in the treatment of these diseases, how easily they may obtain valuable knowledge from the study of its pages.—*Am. Practitioner,* Nov. 1877.

Decidedly the best work on the ear for the general practitioner yet written.—*St. Louis Medical Brief,* Nov. 1877.

HENRY C. LEA, Philadelphia.

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VOL. XXXVI. FEBRUARY, 1878. No. 422.

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GOSSELIN'S CLINICAL LECTURES ON SURGERY . . . . 16 PAGES.

CLINICAL LECTURES.

ON DYSPAREUNIA.

BY T. GAILLARD THOMAS, M.D.,
Professor of Obstetrics and the Diseases of Women and Children in the College of Physicians and Surgeons, New York.

(Reported by P. Brynberg Porter, M.D.)

GENTLEMEN: The case which I bring before you to-day is one of considerable interest in several respects; but there is one special feature about it upon which I should like to dwell at some length a little further on. The patient's name is Mrs. Rose G., aged thirty-eight years. She is a native of Ireland, has been married fourteen years, and has had five children and one miscarriage. Her youngest child is two years old, and the miscarriage, which was at the third month, occurred two months ago. Though never very robust, she tells us that the trouble of which she now complains has been experienced only since July last (four months). She suffers continually from a fixed pain seated in the right iliac fossa, and not infrequently extending down the lower extremity of that side as far as the toes, and chiefly affecting the great toe. It always runs down the anterior and inner aspect of the limb, and never the posterior part as well. At the time of the menstrual periods this pain becomes very greatly increased, and extends around to the back, which is never the case at any other time. At the last two menstrual

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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epochs it has been so severe as to confine her to bed, and cause her the most intense suffering. It becomes severe, she says, about two days before the catamenia make their appearance; but when the flow begins, it again diminishes. From the history to which you have just listened, my suspicions were at once excited in regard to one organ, and that was the right ovary. But why not the uterus or left ovary? Because of the seat and peculiar character of the pain, which, you will remember, is fixed at all times in the right iliac fossa, is excessively aggravated and extends around to the back, at the menstrual epochs (and at this time only), by reflex action runs down the inner side of the leg to the great toe, becomes increased two days before the appearance of the menstrual flow, and, lastly, is relieved when the flow begins. These are the peculiarities of ovarian pain, and whenever they are noticed you should always suspect one, or perhaps both, of these organs. Putting a few direct questions to the patient, we find that she suffers constantly from leucorrhœa, but has no irritability of the bladder or rectum; and that the pain of which she complains has been much worse during the last two months (or, in other words, since her miscarriage) than it was before.

In the physical examination, with the patient lying on her back, the first thing that I noticed when I passed my finger into the vagina was, that the os uteri was not in its normal position, but considerably higher up than it ought to have been; and I also found that the cervix was lacerated to a certain extent. Carrying the finger back of the cervix, I felt a soft mass apparently connected with it, which I suspected to be the body of the uterus; and on conjoined manipulation, which was made without any difficulty, after a few forced expirations, on account of the laxness of the abdominal walls, I ascertained with certainty that the uterus was enlarged, retroverted, and tender on pressure. But this was not all that I discovered; for, upon pressing over the right broad ligament with the hand that was upon the abdomen, I detected a pulpy mass of the size of an English walnut lying back of the uterus in Douglas's cul-de-sac, and so exquisitely sensitive that the patient cried out with pain the moment that I touched it. Now I was fully prepared to find such a body in this position, and would have been much disappointed if I had not, because the history pointed so evidently to chronic ovaritis of the right side. It might, perhaps, be supposed that the body which I felt was either a fibroid or a small phlegmon; but fibroids are not sensitive, and cannot be pushed away from the uterus, as I found it possible to do with this mass, and though phlegmons are tender on pressure, its mobility also showed that it could not be one of these. Furthermore, the great nervousness of the patient was an additional reason for supposing it to be an ovary.

The patient was now placed upon the side, and a Sims speculum introduced, when the ovary was pushed completely up out of reach. In order to confirm the diagnosis of retroversion, the uterine probe was passed to the fundus (which did not occasion the patient the slightest inconvenience), and it was found to take a downward and backward direction. Here, then, was a case of laceration of the cervix, hyperplasia, and retroversion of the uterus (the latter being probably caused by the former), and of chronic ovaritis. The patient is at a loss to account for the miscarriage from which she suffered two months ago, but it was no doubt due to one or more of the above abnormal conditions.

But there is one other symptom of the case of which I have not as yet spoken, but which is a very prominent one, and one to which I now desire to call your particular attention, and that is *dyspareunia.* I have already had occasion to allude to it in connection with the first case presented to you at the clinic this session; but to-day I propose to examine a little more fully into its causes and treatment. I accept the term, which means difficult or painful coitus, from Dr. Barnes. It is derived from the Greek word δυσπάρευνος,[1] signifying *ill-mated.* The only way to treat this symptom is to find out all that you possibly can about the cause, and then remove that if it is practicable. Now how shall we approach it in the case before us? When the finger is passed into the vagina, three tender points are detected by it. The first met with is the cervix, at the part where it has been lacerated, for this accident has produced a neuralgic condition here. The second is the congested and displaced uterus, and this may, perhaps, have something to do with its causation; but neither of these conditions, as I would have you particularly note, is often concerned in the production of dyspareunia. Thirdly, we have an inflamed and exquisitely sensitive ovary, and that, you will find, is one of the commonest of its causes. The pain on pressure, too, is far more acute than at either of the other points just spoken of. You remember the aphorism of Hippocrates. *Propter uterum mulier est;* Prof. Peaslee in his work has rendered it more strictly correct by substituting the word *ovaria* for *uterum*. The ovary may be not inappropriately termed the pendulum of the female clock; and I have not the slightest doubt that this woman could be easily thrown into an hysterical condition by a little continued pressure on the diseased organ.

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[1] This is composed of the words δυς and παρέυνος, the latter being made up of παρα and ἔυνη (the marriage bed).

These cases of dyspareunia are often exceedingly troublesome, and they will tax your ingenuity to the utmost when you get into practice. It is a most prolific cause of domestic infelicity, for the husband is made unhappy, and the wife is not only rendered mentally miserable, but suffers from the most profound derangement of her nervous system. The causes of dyspareunia are numerous, but I will endeavour to enumerate all that you will be at all likely to meet with. You will be pretty certain to find one or more of these conditions present in every case of the affection in which you are consulted, and if you will bear them in mind, you will be surprised to see how often you can remedy the trouble, and how much real happiness you will thus have the means of conferring. You all know how much a man is physically disordered when he is unhappy; a woman's disorder is always tenfold greater from the same cause. The first cause that I will mention is—

Hyperæsthesia of the Hymen and Ostium Vaginæ.—If you will recall the case of vaginismus which I showed you about a month ago, and the extreme suffering which the mere attempt to introduce the finger within the vulva occasioned the patient, you can readily appreciate why this should be a very prominent cause of dyspareunia. But it sometimes happens that after this condition has been removed, the symptom still persists, because there has been some other cause present as well.

(2) *Diseased conditions of the Os and Cervix Uteri.*—Lacerations sometimes produce it, as we have seen, and it is also occasioned by hyperplasia of the cervix resulting from chronic inflammation of its lining membrane, which affects the nerves supplying the parenchyma.

(3) *Stricture of the Vagina.*—This is sometimes congenital and sometimes the result of the exanthemata or of continued fevers, like typhoid and typhus, occurring during childhood. I have seen one case in which it followed measles. Sloughing of the vagina was a concomitant or sequel of the disease, and a stricture was its result. Such strictures often escape notice entirely until after marriage, for they do not amount to complete atresia of the vagina; but while they permit a free passage of the menstrual blood they present an effectual barrier to sexual intercourse.

(4) *Pelvic Cellulitis and Peritonitis.*—These are two of the most irremediable causes that you will meet with. As a result of the inflammatory process, the whole pelvic roof becomes, as Dougherty expresses it, as hard as a deal board, and often extremely sensitive to the slightest pressure upon it.

(5) *Uterine Displacements.*—The dislocated organ is in a neuralgic condition, because there is marked derangement of its innervation and circulation. Unlike the last, this condition is one of the most curable of the causes of dyspareunia.

(6) *Coccyodynia.*—The attention of the profession was first prominently directed to this affection by Sir James Y. Simpson,

but it was really observed before this by the late Dr. Nott of this city. There are two forms of it, one purely neuralgic in character, and the other an actual disease of the bone (caries), and the latter is much the more severe. There is sometimes a most violent pain during defecation from it, and sometimes a continued neuralgic condition of the coccygeal nerves.

(7) *Fissure of the Anus*, and

(8) *Irritable Urethral Caruncle.*—The latter is a little proliferation of the structures of the mucous membrane at the meatus urinarius, usually about the size of a small strawberry, and having loops of nerves running down into it, which render it excessively painful during micturition and coition.

(9) *Chronic Cystitis.*—This is quite a common affection among females, though it is, perhaps, a somewhat rare cause of dyspareunia. But sometimes the inflamed viscus is acutely sensitive, and the irritability which characterizes it is communicated to the adjacent parts.

(10) *Short Vagina.*—This is another cause which is congenital, and which remains unaltered through life. The uterus remains in a constant state of irritation from coitus (which occasions the patient very great suffering), and continually pours forth a glairy discharge of mucus. The greatest unhappiness to both man and wife frequently results, and to illustrate this I will relate a case which came under my notice some time ago. The husband was a vigorous man of powerful physique, and, though very wealthy, of not much refinement. His wife, unfortunately, suffered from the trouble which we are now discussing, and in consequence he became exceedingly morose, and at length left her altogether. He then got into bad habits, and about a year ago committed suicide; this melancholy result being attributable, as I believe, to the condition spoken of. Of course, I may be mistaken in my explanation of the case, but from the circumstances I can hardly doubt that it is the true one. Before leaving it, I may say that, owing to the constant discharge from the cervix, the patient was never pregnant.

(11) *Disproportion.*—As we read in the Scriptures that "there were giants in those days," so there are now. To no class of cases can the original signification of the word dyspareunia, "ill-mated," be more appropriately applied. This is one of the causes which, as you may readily imagine, is the most irremediable, and this unfortunate abnormal development on the part of the male often occasions the greatest amount of distress Lastly, we come to the cause which is no doubt the true one in the case before us, and which I have left to the last not because it is an unimportant one, but simply for the reason that it exists in our patient, viz.:—

(12) *Chronic Ovaritis.*

There are two other conditions which occasionally produce dyspareunia, but I would not rank them with those already given, because when present they are accompanied by other symptoms which are much more prominent than this. They are—

(13) *Malignant Disease of the Cervix.*—And—

(14) *Fibroids situated near the Cervix.*—These are ordinarily not at all sensitive; but if they take on an inflammatory process, as is occasionally the case, they become so.

I now propose to speak of the removal of some of these causes. The first step towards this in any given case is, of course, to ascertain what is the true cause of the dyspareunia. Have we done so in the present instance? I think so, but am not positively sure in regard to it. I think it probable that if the inflamed ovary could be kept up in its proper position in the pelvis, where it would be out of reach of the irritation produced by coitus, and its present diseased condition be somewhat ameliorated, the dyspareunia would entirely disappear. But, as we have seen, there are other conditions present here which may possibly give rise to the symptom. How shall we then decide? Well, we may regard the matter as pretty certainly determined by the fact that the ovary presents the point of maximum tenderness, the sensitiveness of the other two points before mentioned being insignificant compared with it. If the first cause upon the list, viz., hyperæsthesia of the hymen and ostium vaginæ, were present, the mere attempt to separate the labia would occasion the patient an extreme amount of suffering, and produce a high state of nervous excitement. I have so recently spoken of the treatment in this condition that it will be unnecessary for me to go into the subject now. If there is some diseased condition of the cervix, like the laceration in the present case, a careful digital and specular examination will reveal all that is requisite to enable us to relieve it. If there is a stricture of the vagina, or an abnormally short vagina, the mere passage of the finger will be sufficient to detect the condition, though unless the greatest care is observed we may be deceived as to the fact of a vagina being really too short. If dyspareunia is the result of pelvic cellulitis and peritonitis, we would find great tenderness existing all over the hypogastrium, when conjoined manipulation is attempted, and about the roof of the pelvis. We may also find hard masses of exudation or collections of pus, which have resulted from the inflammatory affection.

Some of the other conditions mentioned must be looked for very carefully, or we shall fail to discover them. It is astonishing how frequently patients, in describing their symptoms, will entirely omit to mention the most important of all. A woman, for instance, will come to you with a vague account of some dyspeptic derangement, and never say a word about the pint of blood which she may have vomited a day or two previously. I once knew of a sailor on a man-of-war who, while under treatment for fracture of the thigh by the young assistant surgeon of the ship, was visited by the fleet-surgeon in his rounds, and described to him a long train of symptoms, but neglected altogether to mention the broken leg. Intense agony during defecation is the most prominent symptom of fissure of the anus, and yet those who suffer from it will sometimes not mention it, because females, as a rule, dislike very much to speak of this condition. You know how much suffering a little crack at the corner of the mouth will occasion in cold weather, giving rise to some neuralgic pain which extends as far up as the eye. The pain from fissure of the anus is of the same character, but infinitely more intense, and during the act of coition affects the nerves of all the surrounding tissues. Pain is thus transmitted all over the vagina, and the same is true in regard to coccyodynia. We must be very careful not to overlook a sensitive urethral caruncle. It is apt to give rise to great irritability of the bladder; but irritability of this viscus is so frequent an occurrence in females that they seem sometimes to regard it as really a natural condition, and will not remember to mention it. So chronic cystitis not infrequently entirely escapes notice, and though it is often a very intractable affection, it is frequently amenable to treatment by means of free dilatation of the urethra, which enables us to keep the bladder thoroughly washed out by the use of appropriate injections. As I have previously indicated, nothing can be done where there is a congenitally short vagina, or when disproportion is found to exist.

But chronic ovaritis especially concerns us to-day, and I am confident that we can do a great deal of good in the way of treatment in this particular instance. We shall utterly fail in all our attempts to give relief here, however, unless we can raise the ovary out of its present position and keep it so elevated. It was demonstrated that it could easily be forced up out of Douglas's cul-de-sac when the speculum was introduced, and I would now recommend that it should be retained in its natural situation by some appropriate form of pessary. The shape and size of the vagina vary so greatly in different individuals, that in any case whatever in which a pessary is to be worn, it is absolutely essential that only one especially adapted to it in every way should be inserted. There is too much indiscriminate use of pessaries at the present day, and this I believe to be one great reason why they so often do harm, and why they have gotten into such bad repute in certain quarters. In the present instance I might, perhaps, at first make use of the simple elastic rubber ring, known as Meigs's pessary; and finding that this did not accomplish the result designed, I might employ Hodge's or Albert Smith's modification of that; or, more probably, I might resort to a modification of Cutter's very excellent pessary, which is retained in position by an elastic band attached to an abdominal belt, and whose essential feature is a hard-rubber bulb which fills up all the post-uterine space, and would thus effectually keep the ovary up out of Douglas's cul-de-sac.

Further than this, the patient should be instructed to remain very quiet at the time when physiological congestion of the ovary occurs. For several days before each menstrual period she should lie in bed, while the bowels should be kept relaxed and every possible source of irritation removed. When the flow makes its appearance she should be allowed to get up again, for she is to be treated not for disordered menstruation but disordered ovulation. There is one remedy which seems often to have a favorable influence in these cases by allaying nervous excitability, and that is bromide of ammonium. I am in the habit of giving it in from ten to fifteen-grain doses, combined with some bitter tonic, three times a day for four or five days at the menstrual epoch; always taking care to antedate somewhat the period of ovulation.

Lastly, galvanism should be given an extended trial here; the constant current ought always to be used in such cases. I would recommend that about twice a week one sponge electrode, mounted on a long handle, should be applied directly to the ovary, or as near to it as you can get in the vagina; and that the other, a broad, flat one, should be applied successively for a few minutes to the abdomen, and the spine, near the dorsal vertebræ. I have been told by specialists in electro-therapeutics, that this is a very uncertain method of reaching the ovary with the galvanic current; but as they have been unable to suggest any better way, I still continue to employ it.

On Horsehair as a Drain for Wounds — Prof. Lister, in the course of a clinical lecture on a case of excision of the knee-joint (*Lancet*, Jan. 5, 1878), called special attention to the manner in which drainage was provided. He said: Next to the importance of the avoidance of putrefaction in wounds is the prevention of tension by providing a free escape for effused blood and serum. This we have hitherto generally done by means of the caoutchouc drainage-tube of Chassaignac. But in the present case such a tube would have been unsuitable, because the natural position for the drain was that it should run between the ends of the bones which, as we have seen, were pressed together, so that the calibre of a caoutchouc tube would have been altogether obliterated, and the drain in a most important part of its course rendered useless. Under these circumstances I used a drain of horsehair, because such a drain operates by capillary attraction through the interstices between the hairs, and those interstices cannot be obliterated by pressure, seeing that the hairs are not individually compressible.

The drain was introduced in a manner which you will often find useful. It may frequently happen that the most dependent part of a wound may have no opening in the skin to correspond with it; thus after excision of the mamma it may turn out, when the operation is concluded, that the wound presents a pocket extending considerably further back than the outer angle of your incision. Under such circumstances it is desirable to make an opening for the exit of the drain at the most dependent part. Now, if this were done by a puncture with the knife, some arterial branch of considerable size might be wounded, involving the necessity of freely enlarging the wound to secure the bleeding point. But if you take a pair of dressing forceps, and bore steadily from within outwards, the conical extremity of the instrument will slip past any arterial branch or nervous trunk without injuring it, and when at length it is apparent that there is nothing but skin between the instrument and the surface, the tough integument is divided with a knife over the point of the forceps, and the blades being forcibly expanded so as to enlarge somewhat by laceration the opening which has been made in the muscles, or other deeper textures, the drain is seized between the blades of the forceps, and drawn into place. So in the present case the most eligible position for a dependent opening was at the outer aspect of the limb, where the use of a knife would have involved the risk of injuring the external popliteal nerve, or of dividing some articular arterial branch. Any such difficulty was avoided by employing the dressing forceps in the manner described.

It is only right that I should mention, when alluding to the horsehair drain, that its use did not originate with myself. We were led to its adoption in the following manner: Mr. Chiene, of Edinburgh, suggested some time ago the employment of catgut as a substitute for the caoutchouc tube. He hoped by this means to provide adequate drainage through capillary attraction, and at the same time, by virtue of the proneness of the catgut to absorption, to do away with the necessity for the withdrawal of the drain from time to time, which there is when the caoutchouc tube is used, whether for the purpose of shortening the tube or substituting a small one for a large. Mr. Chiene's anticipations were to a considerable extent realized. In all cases in which the wound remained aseptic the absorption of the deeper part of the catgut drain, and consequent falling off of the part outside the wound, might be reckoned on as a matter of course; and in several cases in which the catgut was so used, both by Mr. Chiene and afterwards by myself, the drainage proved adequate and satisfactory. Mr. White, of the Nottingham General Infirmary, afterwards substituted horsehair for catgut; not because it was supposed to be superior, but because, whereas the prepared catgut is a somewhat expensive article, a horse's tail is a very cheap one. A notice of this use of horsehair was published by Mr. White's house-surgeon, Dr. L. W. Marshall, in *The Lancet* of Dec. 2d, 1876; and in the following month it was employed by myself, in the Edinburgh Royal Infirmary, in a case of chronic bursitis of the sheaths of the flexor tendons at the wrist, in which it seemed likely to be peculiarly serviceable. In this affection the bursa is distended both above the wrist and in the palm, the cavities thus constituted being connected by a constricted passage under the annular ligament; and it is desirable that both the expanded parts should be opened to give exit to the fibrinous concretions which are generally present (varying in size from that of a millet-seed to that of a small bean), and, further, that drainage should be provided for effused serum, the operation being performed antiseptically, in order to avoid the very serious inflammatory disturbance and suppuration which are otherwise apt to occur. I had previously used the caoutchouc tube as a drain in such a case, but I found a difficulty from the liability of the tube to be compressed by the tendons. This might, I thought, be overcome by the use of the horsehair drain, which at the same time would, for this particular purpose, be superior to one of catgut, because the catgut would probably be absorbed before the necessity for drainage would be over. Accordingly I cut down above the wrist, making my way between the tendons of the flexor sublimis to the distended sheath of the flexor profundis, and, as soon as this was opened, passed in a large bullet-probe, somewhat curved, slipped it along under the annular ligament, and pressed it forcibly towards the palm, so as to perforate the palmar fascia while avoiding injury to the palmar arch, and, having divided the skin over the point of the probe, dilated the opening in the fascia with dressing forceps, and then passed into the eye of the probe a substantial drain of horsehair, which had been well purified by steeping in a 1 to 20 solution of carbolic acid, and withdrew the probe, leaving the horsehair drain in its track. The drain answered admirably, and presented the further great advantage that it could be reduced in bulk in accordance with the diminution of the serous discharge, by drawing out as many hairs as might be desired; and in the course of three weeks, the last portions of the drain having been withdrawn, the wound healed without the occurrence of suppuration from first to last.

While the horsehair has the advantage over the catgut that it can be used when necessary over a longer period, it has, in some cases, the converse superiority that it can be not only reduced in bulk, but withdrawn altogether at an earlier period than is required for the absorption of the catgut; for the catgut, in process of organization and absorption, becomes more or less incorporated with surrounding tissues through the medium of the cells of new formation which invade it, and, if an attempt is made to withdraw the drain in whole or in part, there will often occur inconvenient oozing of blood through the rupture of newly formed vessels. And if, on the other hand, the drain is left intact till the parts of the catgut within the wound are entirely absorbed, there remains a small granulating sore at the place of exit of the drain, which may retard for some days the complete healing of the wound. Further, the threads of the catgut, as they undergo organization, are increased in bulk by the formation of the new cells, and their interstices are liable to be more or less choked, so as to interfere with effective drainage. The horsehairs, on the other hand, lie unchanged among the tissues, and their interstices remain to the last as effective as they were at the outset.

The next case in which I used the horsehair drain was one which you yourselves witnessed—viz., that of transverse fracture of the patella, treated by laying open the joint, drilling the fragments obliquely, and tying them together by means of strong silver wire. Being apprehensive that blood and serum might be effused into the joint to such a degree as to produce inconvenient tension unless a free exit was provided, I resolved to introduce a drain at a dependent part of the articular cavity; but I feared that, if a caoutchouc tube was used, it might be rendered inefficient by being compressed between the condyle of the femur and the neighbouring tissues. I therefore had recourse to the horsehair, introducing into the posterior and outer part of the joint a drain, about a quarter of an inch in thickness, by means of the dressing forceps employed as before described. It worked to admiration; for, though there was, indeed, in the first twenty-four hours, a very copious sanguineo-serous effusion, as shown by the soaking of the antiseptic gauze, yet not the slightest swelling of the joint occurred, and, after nine days, the small remains of the drain, which had been previously reduced at successive periods, were withdrawn, to allow the puncture to close. The drain of horsehair was as pure and white[1] as if it had been merely dipped in water; having been washed quite clean of the blood which first occupied its interstices by the colourless serum which, after the cessation of the original sanguineous effusion, had been the only discharge. I was so much impressed with the satisfactory working of the horsehair drain in that case that we have since employed it in preference to the caoutchouc tube in all our wounds, and have had good reason to be pleased with the change. (If it be necessary to reintroduce a horsehair drain, it is readily done by taking a wisp of hair of half the thickness required, bending it in the middle at a sharp angle over a probe, and tying a piece of carbolized silk round it close to the probe, on withdrawal of which the drain is left with a rounded end which passes readily into the interior of the wound.)

In the case of this little girl the horsehair drain has worked perfectly well in spite of the pressure to which it was subjected. The flow of blood and serum was, in the first twenty-four hours, extremely free, but there was no appearance of the retention of any of it within the wound. On the occasion of the last dressing, two days ago, more than half of the drain was removed. That dressing took place after an interval of three days, and it would be superfluous to change the dressing to-day, were it not that we may, perhaps, be justified, by the further diminution of the discharge, in withdrawing the remainder of the drain entirely so as to permit its track to close.

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[1] I used white horsehair in this case simply because I did not happen to have at hand any of the black, which is generally preferable, because the individual hairs are thicker, while the dark colour has the advantage of making them more conspicuous, especially when they are used for sutures.

HOSPITAL NOTES AND GLEANINGS.

Cases of Stricture of the Pylorus treated by withholding Food.—A dock-labourer, aged 41, was admitted to the London Hospital, under the care of Dr. SUTTON, complaining of inability to take solid food, as it always produced great distress; he also complained of heartburn and frequent vomiting. Upon inquiry, it appeared that he had suffered at intervals from severe dyspeptic symptoms during two years, the attacks having become more severe and more frequent of late, so that he was at last unable to take meat or solid food of any kind. He had also often been much distressed by a feeling of tightness across the abdomen, increased by food and relieved only by vomiting, so that he frequently put his finger to the back of his mouth to cause regurgitation. His habits were temperate. Dr. Sutton remarked that the order of symptoms was not indicative of chronic ulcer or of gastric catarrh. The sensation of tightness in the abdomen, the oozing of mucus, and frequent sour rising into the mouth, rather pointed to incipient stricture of the pylorus; and the constant vomiting strengthened that idea, although no distinct thickening could be felt through the abdominal walls. The emaciation might be attributed to the constant vomiting and inability to take food.

While under observation, he frequently vomited yeast-like acid matter containing sarcinæ, which, when kept, rapidly underwent fermentation; he was much troubled by flatulence and headache. Food was given in small quantities, consisting of mince-meat, with very little bread and eggs beaten up with milk arrowroot. The stomach was washed out every day with warm water by means of the œsophageal tube. Under this method of treatment and rest in bed, he improved much in general condition; the vomited matter became less fermentable, and the sarcinæ disappeared.

Relapses, however, occurred, and, at two periods of the treatment, he was fed for three days by nutrient enemata only, no food being taken by the mouth, except a little brandy and water. This plan did not greatly try the patient, and produced a marked relief of the symptoms. The man was under treatment for three months; during that time he improved much in general appearance, and gained seven pounds in weight.

The second case was that of a man aged 55, who, on admission, complained of "windy spasms" and inability to keep down food. He was a blacksmith, and, during adult life, had enjoyed good health, but his habits had not been temperate. He said that, for four or five years before coming to the hospital, he had suffered from distension after food, otherwise his health had not failed till the last three or four months, when vomiting of food became frequent and troublesome. Food caused distress, which was relieved only by vomiting. Formerly, he had been stout, but lately he had become emaciated, and his weight reduced from ten stones to seven stones and a half; his appetite had continued good, but he was afraid to eat. There was neither cough, heartburn, nor jaundice, and, on physical examination, the stomach appeared enlarged, and a distinct thickening was felt in the neighbourhood of the pylorus. It appeared probable that the man was suffering from a slowly growing scirrhous infiltration of the pylorus, causing stricture. Other treatment failing to arrest the vomiting, he was ordered to take no food by the mouth for three days, except a little brandy, and was fed by nutrient enemata. Great relief of the symptoms was thus afforded; the vomiting and feeling of distress subsided, and he was again able to take light food, while the stomach was washed out daily.

He was thus kept in comparative comfort, though the disease slowly advanced, and he died three months after his admission to the hospital.—*Brit. Med. Journ.*, Dec. 8, 1877.

A New Operation for Fracture of the Patella.—In a case of fracture of the patella treated at King's College Hospital, Mr. **Lister** cut down on the fragment, opening the knee-joint, cleansed the surfaces of the fragments, and, having established an independent drain of horsehair for the knee-joint, drilled the two portions of the patella and tied the fragments together with silver wire, and then closed the wound, which was also also drained with horsehair.

This operation was performed six weeks ago; the wound, as exposed to-day, was seen to be completely healed, the ends of the silver wire projecting through the scar. The highest temperature that had occurred was 100 deg. Fahr. on the morning after the operation. There has been no disturbance, constitutional or local, and both the wounds healed in about a fortnight.

The limb will be kept at rest for another fortnight, when, if union have taken place, the wires will be withdrawn.—*Brit. Med. Journ.*, Dec. 15, 1877.

MEDICAL NEWS.

DOMESTIC INTELIGENCE.

Rectal Alimentation.—In some recent remarks on this subject (*Med. Record*, Jan. 19, 1878), Dr. **Austin Flint** recommends a variety of diet rather than the persistent use of the same kind of food prepared in precisely the same way. The articles now used were meat solution, pancreatic emulsion, Liebig's extract of meat with or without milk, milk, eggs, mutton and chicken broths. A pancreatic meat emulsion was mentioned, made as follows: From five to ten ounces of finely chopped meat were added to fully one-third of that weight of the fresh pancreas of the ox, the fat being removed, and mixed with about five ounces of water; the whole was reduced to the consistence of a thick soup.

In cases in which the rectum was or became irritable, one-half of a pint of milk could be carried up into the colon and be retained without difficulty. The average quantity of material to be employed in this mode of treatment was from three to six ounces, and the intervals between the injections might vary in length from three to six hours. Small quantities of some preparation of opium might be added to the injection, if they were not well tolerated. It remained to be settled whether or not opium had the same influence upon rectal as upon gastric digestion—namely, to impair it. Preparatory to the beginning of the treatment, the bowels should be emptied either by means of enemata, or by a laxative given by the mouth. As a substitute for drink, when necessary, simple water may be thrown into the bowel, and the surface of the body freely sponged.

At first nutritive injections might not be retained; but, if persisted in, they would soon be well tolerated. On the other hand, in some cases they were well tolerated at first, but after a time they were not retained. In such cases it was well to stop them for a short time, when they could probably be renewed with success. It was not thought necessary to wash out the rectum each time prior to using the administration of the nutritive injection. The nutritive injection should be *tepid*. Firm pressure should be made over the anus with a sponge or towel, until the desire to remove the injection had passed away. If the nutritive injections met the requirements of the case, there would follow a sense of comfort and satisfaction the same as after taking a meal in the ordinary way.

With reference to irritability of the rectum such as prevented retention of the nutritive injection, even though opium was added, Dr. **Fordyce Barker** had overcome that difficulty by passing the tube high up into the colon, so that the fluid would be thrown into the intestine *above* the rectum.

Report of the Surgeon General.—The annual report of the Surgeon General of the Army has been published, and the profession will be pleased to learn that the work of cataloguing the original papers in medical journals and transactions has been completed to date for all this class of literature which the library has been able to obtain; and the classifying these titles under the proper subject headings, and combining them with titles of works, in order to form a complete index to the collection, has been effected to a great extent. Of the value of this work there can be no question, and we hope that every physician will use his influence with Members of Congress to procure the authority for the printing of this catalogue by the Government Printer, which has been asked for.

The second volume of the Medical History of the War of the Rebellion it is expected will be ready for issue by June of this year.

The Boston Medical and Surgical Journal.—The retirement of Dr. Thomas Dwight from the editorial management of the *Boston Medical and Surgical Journal*, in which he has been associated for the past five years with Dr. J. Collins Warren, is announced. Our Boston contemporary thus speaks of the services he has rendered to it: "The many changes which the Journal has undergone during this, a not uneventful, period in its history, and the favorable results which have followed therefrom, are in no small degree due to his able management and his courageous stand in delicate questions involving professional interests or public welfare, where his power for satire or praise and his ability in argument have forcibly displayed themselves, and have contributed to the increased influence exerted by the Journal upon the community as well as the profession in which it circulates."

In the retirement of Dr. Dwight, medical journalism has lost a valuable coadjutor, and our contemporary an editor whose able pen undoubtedly did much to win for it the high esteem with which it is justly regarded.

Personal.—Dr. W. R. WHITEHEAD, formerly of New York and recently of Colorado, has removed to Paris, where he is now practising at No. 14 Rue d'Alger.

OBITUARY RECORD.—At New York, on the 21st of January, aged sixty-four, EDMUND RANDOLPH PEASLEE, M. D., LL.D., Professor of Gynæcology in Bellevue Hospital Medical College, President of the American Gynæcological Society, and Surgeon to the New York State Woman's Hospital.

Dr. Peaslee was born at Newton, N. H., in 1814, and graduated in the arts at Dartmouth College in 1836. He took his degree in medicine at Yale in 1840. From that time to the present he has been actively engaged in medical teaching. In addition to his contributions to the pages of the *American Journal of the Medical Sciences*, Dr. Peaslee, in 1857, published a work on Human Histology, and in 1872 an elaborate treatise on Ovarian Tumours and Ovariotomy, which will long remain an authority on the subject of which it treats. Dr. Peaslee was greatly respected for his professional skill, and held in high esteem for his personal worth. He was elected, in 1871, President of the New York Academy of Medicine. He was formerly Professor of Anatomy in the New York Medical College, and Professor of the Diseases of Women in Albany Medical College.

Dr. Peaslee died of pneumonia after a few days' illness.

FOREIGN INTELLIGENCE.

Mr. Spencer Wells and the Samaritan Hospital.—On Dec. 12th Mr. SPENCER WELLS performed ovariotomy for the 404th time at the Samaritan Hospital. After the operation, he remarked that it was twenty years since he first joined the institution, which was then a dispensary. His first ovariotomy in connection with the institution was done about twenty years ago, and fortunately the first three cases recovered. Had they proved fatal the history of ovariotomy would probably have been different, and the operation might have remained under a cloud. The mortality in each quinquennial period had steadily diminished; it being one in three during the first five years, one in four in the next five, and one in five in the third five years. Still more recently it had been only one in ten. The total number of deaths among the 404 cases was 99. Other operations than ovariotomy had been done in the hospital; for example, amputation at the hip joint, removal of the lower jaw, and operations for vesico-vaginal fistulæ and ruptured perineum, and these showed that better results were obtained when the same care was bestowed upon them as upon the ovarian cases. The hospital was not perfect, but practically it afforded very good results. Mr. Wells then mentioned that he was now retiring from the active work of the hospital, having been elected consulting surgeon, and that this was probably the last operation he should perform there, unless he operated again next week. But it had been arranged that public consultations should be held at the hospital every Friday; due care being taken to respect the feelings of the patients.—*Lancet*, Dec. 15, 1877.

Salicylic Acid.—M. Sée informs the correspondent of the *Brit. Med. Journ.* (Dec. 15, 1877), that his success with salicylic acid has been so unexpected and overwhelming in the cure of rheumatism and gout that he has been induced to try it in other analogous complaints, such as arthritis, produced by surgical or other causes, and the results have been identical with those effected in gout and rheumatism; viz., marked amelioration, if not complete cure, in two or three days. He is not prepared to explain the *modus operandi* of salicylic acid in these cases; but believes that, besides being an analgesic, it promotes the absorption, and prevents the reproduction, of morbid products, thus rendering *nil* one of the principal arguments brought against it by its detractors, that it would favour rather than prevent valvular disease of the heart and great vessels The detractors of the new remedy put forward as another argument against it the constant failure they have met with in their practice, to which M. Sée replies that it is not the medicine that is to blame, but the failures are owing most probably to the timidity with which certain practitioners have prescribed it; for, to be effective, it must be administered in sufficiently large doses: four to six *grammes* (sixty to ninety grains) a day of salicylic acid, or eight to ten *grammes* (one hundred and twenty to one hundred and fifty grains) of the salicylate of soda. He gives a decided preference to the latter, as being more soluble and more manageable, and prescribes it largely diluted in the proportion of one-tenth. Sometimes, however, severe gastric symptoms arise; but, in the great majority of cases, they may be put down to the impurity of the salt. Sometimes the salicylate produces other disagreeable symptoms, such as deafness, tinnitus aurium, and a peculiar cerebral disturbance; but these need not alarm the physician, as they soon vanish on a discontinuance of the medicine for a short time. Another accusation brought against it is its toxic action on the system even in moderate doses. Here M. Sée observes that, if pure, the salicylate of soda may be administered to the extent of twenty *grammes* (three hundred grains) a day, without fear of poisoning the patient, as the salt is so quickly eliminated, that it can have no time to accumulate in the system.

Antiseptic Surgery.—In an interesting clinical lecture on the Treatment of Compound Fractures (*Med. Times and Gaz.*, Nov. 24, 1877), Prof. Richard Volkmann says that during the past four years and a half he has treated conservatively by the antiseptic method seventy-five cases of compound fracture of the extremities occurring in seventy-three patients. "A small proportion of these—eight altogether—had to be subjected to secondary amputation. But neither of those who were treated throughout on conservative principles, nor of those where the conservative treatment failed, and where secondary amputation had to be undertaken, did one single patient die; *they one and all recovered!*

"As I am not the inventor of the 'antiseptic method' of treating wounds—the greatest advance which surgery as a science has ever made—you will not consider it boasting if I venture to call this a very remarkable result; indeed, as compared with our former experience, it is quite an unheard-of result. For the mortality of such injuries, until the antiseptic method was discovered, was a very high one, no matter what treatment was adopted."

And he again says, "But now, since the introduction of the antiseptic method of treating wounds, I get more successful cases in a single year than I had previously done during the whole of my surgical career."

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Iodoform in Fissure of Anus.—M. **Tarnier** recommends (*Union Med.*, Dec. 27) the spreading of a small quantity of the powder of iodoform over the surface of a cotton plug, and bringing this in direct contact with the fissure. Four or five dressings suffice in some cases to produce a cure.—*Med. Times and Gaz.*, Jan. 5, 1878.

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Relation between Urinary Secretion and Irritation of Spermatic Plexuses.—M. **Nepveu** read a paper at the Havre meeting of the French Association for the Advancement of Sciences, in which he gave the results of his continued researches on the variations which the urinary secretion may undergo as a consequence of various traumatisms. He has arrived at the conclusion that the testis may, in certain abnormal conditions (such, for example, as follow injections of iodine into the tunica vaginalis, and in neurosis of the testis), be the starting point of reflex actions affecting the urinary secretion. This reflex action, looked at especially as a result of injections of iodine into the tunica vaginalis for hydrocele, is exhibited by a series of oscillations in the secretion, the first effect being oliguria or deficient secretion, which lasts for some days, and is followed by polyuria, succeeded by a return to the normal condition. This result of the injection of iodized solutions into the tunica vaginalis may be regarded, M. Nepveu thinks, as an experiment which establishes the reality of a physiological connection be- between the renal secretion and irritation affecting the spermatic plexuses.—*Lancet*, Oct. 6, 1877.

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Pneumonomycosis Sarcinica. — Under this name, M. **Heimer** describes in the *Deutsches Archiv für Klin. Med.*, vol. xix., a case of which the following is an abstract. A servant-man, aged 57, admitted into hospital with symptoms of an advanced stage of pulmonary phthisis, was seized on the eighth day with pneumonia of the right lung. The sputa contained fibrinous coagula, pus-cells, granular cells, epithelium, fat, numerous molecules, and a large number of sarcinæ. At the necropsy, there were found thickening, excavation, and caseation of both upper lobes; and the two lower lobes of the right lung were hepatized. In the anterior part of the middle lobe of the right lung was a cyst filled with gas and a little fluid. The gas had no bad smell, and the fluid had an acid reaction. The cavity was about four inches and three-quarters in circumference, and was bounded by the broken-down lung-tissue, which contained a large proportion of sarcinæ. The sarcinæ were colourless, and were found also in the pus-corpuscles. Two similar cases have been described by Virchow, and one by Cohnheim; all occurred in phthisical patients. Heimer believes that his patient took in the sarcinæ by inspiration while in hospital; that, through their very rapid development, they caused localized softening in the lung; and this gave rise to the fatal pneumonia.—*British Medical Journ.*, Nov. 24, 1877.

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Atmospheric Germs.—At the meeting of the Royal Society, on November 29th, a discussion took place on the subject of Professor Tyndall's well-known discoveries as to the influence of the invisible particles of the atmosphere, as exciters of putrefaction. Professor Tyndall has established by his experiments the following remarkable facts: 1. That the air is at all times, even when free from microscopically visible particles, beset with much smaller ultramicroscopical particles which communicate to it, when illuminated by the sunbeam or the beam of the electric light, a peculiar opalescence; 2. That this opalescence disappears when the air is allowed to remain absolutely tranquil; 3. That air which has undergone this change, *i. e.*, air from which the ultramicroscopical particles have subsided, is no longer capable of contaminating liquids. From these facts, Dr. Tyndall concludes that the particles in question are organisms—the germs of septic bacteria. Dr. Burdon Sanderson, admitting the fact that the particles have the influence assigned to them, regards the evidence that they are organisms as insufficient; holding that, in respect of morphological entities, the only evidence that can be taken is that of observation. The present discussion has arisen out of a paper communicated to the Royal Society last summer, entitled, "Note on Dr. Burdon Sanderson's Latest Views of Ferments and Germs," in which Dr. Tyndall criticized certain parts of a lecture delivered in January last on *Contagium Vivum.* In this paper, after referring to certain writers who, he thinks, have wrongly invoked the microscope in deciding the question of ultimate structure, Dr Tyndall proceeds: "It is not without concern that I see the habit of thought and expression against which I thus reasoned revived by so excellent a worker as Dr. Sanderson. My position is, and I think the uniformity of nature is on my side, that a particle, whether great or small, which, when sown, produces a plant, is proved thereby to be the germ of that plant; Dr. Sanderson's position is, that a particle, however fruitful it may be, ceases to be a germ, and dwindles to a molecular aggregrate when it becomes ultramicroscopical. It may be fairly asked, Have all microscopes, or only some, the right to define the germ-limit? Has a pocket-lens the right? If not, and assuredly it has not, what power of enlargement confers the right?" etc. In the introduction to his paper, Dr. Sanderson remarks that the difference between himself and Professor Tyndall appears to him to arise mainly from the difference of meaning attached to the words germ and structure.—*British Med. Journ.*, Dec. 8, 1877.

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Death from Chloroform.—A case of this which occurred at Ancaster, Ont., is reported in the *Canada Lancet* for Jan. 1878. Fatty degeneration of the heart was disclosed at the *post mortem.*

Handy Antidotes.—The French medical profession have frequently occupied themselves with the endeavour to add to their pharmacopœia an antidote which would answer the purpose in the majority of accidental poisonings, and which could always be kept at hand, so that it might be administered at once, before more special indications had the time to develop themselves, either according to information and anamnestics, which are often wanting in cases of accident, or, according to symptoms noted by observation of the patient. M. Mialhe has highly recommended, for this purpose, hydrated sulphate of iron mixed with calcined magnesia. This is a good antidote for the metallic salts, which it deoxidizes and changes into harmless sulphurets. But this antidote has the disadvantage of disengaging sulphydric acid in the presence of acids. It requires great nicety in preparation, and is difficult to keep. M. Dorvault has proposed, in cases of alkaloid, cyanic, and metallic poisonings, an antidote composed of equal parts of calcined magnesia, peroxide of iron, and washed powder of animal charcoal. This mixture also, however, changes if it be kept some time. M. Jeannel proposed to keep separately—1, a solution of sulphate of iron; and 2, a mixture of 80 *grammes* of calcined magnesia and 40 *grammes* of animal charcoal in 800 *grammes* of distilled water. This mixture, added at the moment of using to the solution No. 1, forms the antidote, which is to be administered in successive doses of from 50 to 100 *grammes* (about 1¾ to 3½ ounces). This antidote renders preparations of arsenic, zinc, and digitalis insoluble. It completely saturates free acid, and only acts partially on the alkaline hypochlorites and the oxide of copper. It also leaves in solution a small amount of morphia and strychnia, and the oxide of mercury in notable quantity. Professor Ranieri Bellini has made a communication to the Medico-Physical Society of Florence on the iodide of starch, which MM. Bouchardat and Quesneville were the first to introduce into therapeutics, and frequently employed in cases which required an active alterative medication, when the stomach refused to tolerate iodine in any other form. The iodide of starch is a chemical antidote which is specially appropriate to poisoning by sulphur, by the alkaline or earthy sulphurets, by caustic alkalies, ammonia, or any of the alkaloids. It is also an eliminating agent, very useful in the treatment of long-standing metallic poisonings, especially those resulting from lead or mercury. Dr. Bellini advises that the patient should always be made to vomit soon after the administration of the antidote, to rid him of the chemical products which result from the decomposition of the toxic agent, which in their turn might likewise become decomposed.—*British Med. Journal*, Dec. 22, 1877.

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Iodized Cod-Liver Oil.—Pale cod-liver oil (*Med. Times and Gaz.*, Dec. 15, 1877), one hundred grammes; iodoform, one-quarter of a gramme; oil of anise, ten drops. The iodoform removes from this oil its nauseous and disagreeable odour. M. Fonssagrives prescribes this mixture in the same manner as ordinary cod-liver oil, in cases in which it is desired to combine iodine with it.—*L'Union Médicale*, Dec. 6, 1877.

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Health of Grocers and Drapers.—The *Sanitary Record* says: "Recent statistics show that the rate of mortality among grocers is as 76 to 100 among the general population at equal ages, while the death-rate among drapers is as 108 to 100 by the same standard. On analyzing the cause of this difference between the drapers and the grocers, it is found that it lies in the mode of living. The principal disease which destroys the draper is pulmonary consumption. The explanation is simple: The grocer lives in a shop, the door of which is open the whole day, and he is very active himself in business; the draper, on the other hand, lives in a close place, with the doors of his shop closed, and in a dusty and close atmosphere. No one, whose pleasure or business calls on him to enter the majority of our large drapery emporiums in London, but will feel in a position to testify to the truth of this description. The heat and closeness which are their usual characteristics sufficiently account for the general pallor and unhealthy appearance of the male and female attendants in them."—*Med. Times and Gaz.*, Dec. 15, 1877.

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Poisonous Wall-papers.—A lecture on "Poisonous Wall-papers" was delivered a short time back before the Manchester Chemists and Druggists' Association by Mr. L. Siebold. The lecturer stated that out of sixty or seventy papers of various colours, blue, red, brown, pink, etc., analyzed by him, ten only were harmless, the rest containing arsenic. There is a popular impression that green papers only are to be feared; but the result of Mr. Siebold's examination should have the effect of rendering householders and heads of families suspicious of some of the most innocent-looking colours. It is reasonable to assume that to the presence of deleterious ingredients contained in certain wall-papers may be ascribed many little illnesses of children where no apparent cause exists for the same, and which sometimes puzzle the medical attendant. —*Lancet*, Dec. 29, 1877.

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OBITUARY RECORD.—At Bordeaux, in December last, aged 86 years, M. ELIE GINTRAC, formerly Professor in, and Director of the School of Medicine at Bordeaux.

M. Gintrac was the author of a number of papers on diseases of the chest, but his most important work is his *Theoretical and Clinical Course on Pathology and Medical Therapeutics*, of which eight volumes have been published. It is characterized by erudition, good sense, and great clinical wealth.

——— At Paris, on the 3d of December, aged 72, JEAN-BAPT.-PHILIP. BARTH, Commander of the Legion of Honour, late President of the Académie de Médecine, and Honourary Physician to the Hôtel Dieu.

M. Barth succumbed to an attack of pernicious fever contracted at Rome. *The Traité d'Auscultation*, which he wrote in conjunction with M. Henri Roger, was his principal work, and has achieved for him a well-deserved reputation.

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The American editor has performed his labor of adapting the work to the requirements of our countrymen, in a most thorough and conscientious manner. In conclusion, we would commend the book to all who would have a short and concise manual of the present state of our knowledge of the physiological and therapeutical action of remedies.—*St Louis Clin. Record*, Jan. 1878.

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This is a very valuable book, and is well adapted for a young practitioner. We have every reason to thank the author for a practical and suggestive work.—*London Lancet*, March 24, 1877.

He has succeeded in producing a volume that will be found an exceedingly useful companion to the standard works on practice. It abounds in information of value at the bedside, and is eminently practical throughout.—*N. Y. Med. Journ.*, April, 1877.

We heartily commend his book to the medical student as an honest and intelligent guide through the mazes of therapeutics, and assure the practitioner who has grown gray in the harness that he will derive pleasure and instruction from its perusal.—*Bost. Med. and Surg. Journ.*, March 8, 1877.

We could quote much that would interest our readers; but we desist, referring all to the volume itself as at once practical and scientific; as a treatise for the practitioner simply bent on learning the latest discoveries in therapeutics, and for the inquirer in search of the philosophy of medical practice.—*American Practitioner*, Sept. 1877.

HENRY C. LEA, PHILADELPHIA.

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VOL. XXXVI. MARCH, 1878. No. 423

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CLINICAL LECTURES.

ON PARACENTESIS OF THE PERICARDIUM, WITH A SUCCESSFUL CASE.

BY WILLIAM PEPPER, A.M., M.D.,
Professor of Clinical Medicine in the University of Pennsylvania.

GENTLEMEN: You will remember that, in connection with two cases of pericarditis of moderate severity, which formed the subject of a lecture several months ago, I referred to a desperate case of pericarditis, with effusion, in which it had been necessary to perform paracentesis. My chief object to-day, in returning to the same subject, is to report at length the latter case, and to make a few practical remarks in connection with that operation.

Rapid Pericardial Effusion; Albuminuria; Uræmic Convulsions; Paracentesis Pericardii, with immediate relief; Jaborandi; Recovery; Subsequent disease of other serous membranes.—Sarah C., æt. 17, a well-developed girl, enjoying general good health, had noticed since May, 1877, some shortness of breath on exertion, especially after mounting the long flights of stairs leading to the fringe factory where she worked. She had also been obliged to pass urine more frequently than usual. She had never mentioned either of these symptoms to her parents, fearing that they would make her stop working. In early childhood she had

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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passed through a mild attack of measles; but had never had any other exanthem or rheumatism. On Sunday, September 2, she suffered with præcordial pain. No cause could be assigned for the attack, unless it were that she had been chilled by a draft which blew upon her as she worked. On Monday the pain continued with some sense of oppression. She did not leave the house, but it was not until Wednesday, September 5, that she became quite suddenly so ill as to confine her to bed, when she was seen by Dr. George A. Rex, with whom I saw the case in consultation, and to whose courtesy I am indebted for many of the facts in connection with it. He found her with a very moderate degree of fever, but with some anxiety and distress, and with rapid pulse, frequent breathing, and severe præcordial pain. By Friday, September 7, she was much worse. There was still severe præcordial pain, with great restlessness and distress. The respiration was very frequent and much laboured. The pulse was extremely rapid, feeble, and irregular. The apex beat of the heart was felt with difficulty, and the sounds were feeble and distant, though apparently without valvular murmur. The area of cardiac dulness was increased. The tongue was moist and somewhat furred. The stomach was retentive, though there was no appetite. The urine was rather scanty. From time to time there were paroxysms of terrible dyspnœa and cardiac distress, in some of which she seemed almost asphyxiated. Her condition became, in all respects, somewhat worse during Saturday and Sunday, and, in addition, there were on the latter day two convulsive attacks, with loss of consciousness for a few minutes, and slight muscular spasms of the face, arms, and legs.

I saw her in consultation with Dr. Rex, first on Sunday night, September 9. The patient was lying in bed, with but a single pillow under the head. The face was very pale, and the lips livid; the extremities tended to be cold. There was extreme restlessness and jactitation, with a sense of suffocation if any one even approached her. It was necessary to fan her constantly. The respirations were over 60; the pulse at least 145, very small, feeble, and intermittent. The pupils were dilated; the expression very anxious; the intelligence clear. There were constant complaints of severe præcordial pain. The paroxysms of alarming dyspnœa were now very frequent. On physical examination no lesion of the lungs was found. The præcordia was somewhat prominent. The impulse of the heart could neither be seen nor felt, and its sounds were barely audible, being distant and feeble, and apparently without murmur. The point of their greatest intensity was at mid-sternum, opposite the third interspace. At the normal position of the apex-beat no sounds were audible. No friction sounds were heard. The area of cardiac dulness was much enlarged, and of rudely triangular shape. Its base was on the level of the seventh rib, and extended from one inch to the right of the sternum to two inches to the left of the line of the left nipple; the upper limit of the dulness was the second interspace. Its greatest transverse diameter corresponded to the level of the fifth interspace. Changes in the position of the patient's body produced no effect on the horizontal lines of dulness.

The urine contained a slight trace of albumen, and microscopic examination showed a few fragmentary hyaline or granulo-hyaline tube-casts, and a few cells of renal epithelium. There was no œdema of any part, save a slight puffiness about the ankles. The question of tapping the pericardium was discussed, but the parents would not consent. She had been using digitalis and a diuretic mixture. These were continued, ten drops of digitalis being given every three hours. A blister four inches square was applied over the præcordia. She objected violently to stimulants, even in very small doses, asserting that they immediately caused agitation of the heart, with great distress in the head. On the other hand, Hoffmann's anodyne gave some relief to the paroxysms. During Monday and Tuesday (September 10 and 11) she grew worse, if possible, and had several slight convulsive attacks. I saw her again with

Dr. Rex, late on Tuesday night. She was then dull and listless, with livid lips, and cold extremities. The respirations were mere shallow gasps, 75 to 80 in the minute. The pulse was over 160, extremely thready, and very intermittent. At times, also, the respirations were distinctly of tidal character, ascending and descending, with marked intermissions. Each paroxysm of dyspnœa seemed as if it would prove fatal, and it seemed clear that death would occur before morning. The consent of the parents being obtained, I immediately performed paracentesis of the pericardium, with the assistance of Dr. Rex and of Dr. C. B. Nancrede. The smallest needle-pointed canula of Dieulafoy's aspirator was employed, with a vacuum jar. The puncture was made in the fifth intercostal space, about one inch inside of the line of the left nipple, *i. e.*, nearly in the normal position of the apex-beat. The needle was introduced in a direction upwards and inwards. As soon as its extremity was fully covered by the soft tissues, the communication with the vacuum jar was opened, and the needle was cautiously pushed onwards. When the liquid began to flow into the jar, and the point of the needle was felt to be free in the pericardial sac, the needle was directed somewhat downwards and outwards. Rather more than eight fluidounces of reddish serum were removed, after which the flow ceased. The serum contained a very large proportion of albumen, many red-blood globules, and a large proportion of pseudo-fibrin. No difficulty whatever was encountered in the operation. Once or twice the point came in contact with a firm and apparently roughened surface, which was probably the apex of the heart, coated with lymph. The effect of the operation was magical. The pulse fell to 114, became regular, and much more full. The respirations soon fell to 40, and became much more deep and regular. The apex-beat of the heart could be felt, though still feeble and too high up. The cardiac sounds became immediately much more distinct. The lips grew more red, and the expression improved vastly. She expressed herself as feeling much better, and able to lie quietly. She was ordered iodide of potassium gr. v, and tincture of digitalis gtt. x, each every four hours. The diet of skimmed milk was continued. There was no evidence of any return of pericardial effusion, and for two days she continued very comfortable, although the urine was still faintly albuminous. On Friday, September 15, two severe convulsions occurred; the mind grew dull; the respirations again became rapid, and tidal in character; and the pulse intermittent. On September 16 she continued in a partially uræmic state, with several convulsions. Still, no sign of increased pericardial effusion occurred; but, on the other hand, the area of dulness progressively diminished, and the impulse and the sounds became more distinct. On the evening of this day an enema of infusion of jaborandi (ʒj of powdered leaves in ℥iv water) was given. The effects were rapid and marked—violent headache, repeated vomiting, copious salivation, and drenching sweat, lasting six or seven hours. She passed a more quiet night, and was better the following day. The pulse was now regular, and more full—108 in the minute; and the breathing easier. The cardiac impulse and sounds more distinct, and slight friction sound audible. The use of digitalis, iodide of potassium, and diet of skimmed milk, continued.

She had two convulsive attacks on September 17, and on September 18 three severe attacks, in all of which she was unconscious, with frothing at the mouth, and general convulsive movements. The cardiac symptoms continued to improve. There was a trace of albumen in the urine, but no tube-casts could be discovered.

On September 19, a second enema of infusion of jaborandi was given with the same prompt and severe effect. No further convulsions occurred. The cardiac symptoms improved slowly but steadily. There was no severe dyspnœa after September 28. She was able to leave bed on October 7, twenty-six days after the operation. On October 14, thirty-three days after the operation, she was still pale and weak, though able to be out of bed all day, and to walk about slowly. Respiration was quiet and regular; the lungs were free from any congestion. The pulse was regular and quiet, though easily disturbed by exertion. The præcordia was not prominent. The point of puncture could barely be detected. The apex-beat was feeble, but distinct; it was at the lower border of the fifth rib, midway between the sternum and the line of left nipple. There was neither thrill nor recession of the soft intercostal tissues. No tenderness on pressure existed. The sounds of the heart were still weak, but quite distinct and free from murmur. There was no friction sound, save over the base of the heart where a slight pericardial clicking sound was audible. The area of cardiac dulness was nearly, if not quite, reduced to the normal dimensions. She complained of no palpitation or sense of oppression. The appetite was fair, and some solid food had been taken, although milk was still the chief article of diet. The urine was free, contained no albumen (Heller's test, and heat and nitric acid), and deposited a delicate sediment, containing vesical epithelium, but no tube-casts.

On February 2, 1878, nearly five months after the operation, I again saw the patient in consultation with Dr. Rex. Until the middle of December, the use of a milk diet, and of occasional doses of iodide of potassium, was continued, and the patient's condition remained very good. But in about five weeks, she began to suffer with pain about the chest and in the abdomen. The circulation was at times considerably disturbed. Soon the abdomen began to enlarge, and extensive ascites appeared, followed by œdema of the legs. At one time there was a troublesome vesical catarrh, but otherwise the urine continued normal. The milk diet, and the use of iodide of potassium, was resumed; and improvement soon showed itself. At this date (February 2) the patient is sitting up and quite comfortable. On careful examination of the præcordia there is no extension of area of dulness; the apex-beat is distinctly felt in the normal position; and the cardiac sounds are distinct, though weak, and without either valvular murmur or friction sound. There is no dimpling of the intercostal tissues with the action of the heart, nor any fremitus on palpation.

Over both sides of the chest there is strong, coarse, pleuritic rubbing, evidently due to a small amount of plastic exudation, as there is no dulness on percussion, nor marked enfeebling of the respiratory murmur. There is considerable distension of the abdomen, with distinct fluctuation on palpation. There is some œdema of both legs, but much less than a few weeks ago. The amount of dropsy has greatly diminished, and the general condition of the patient has improved since resumption of milk diet and iodide of potassium.

Remarks.—It will be seen that in this case the preservation of life was solely due to the operation of paracentesis. It seemed abundantly evident that, on the evening of September 11, without immediate operative relief, life could not be supported through the night. The renal complication which existed was probably due to the pericarditis and, after the heart's action was liberated, it became possible to deal successfully with the uræmic symptoms. In this connection, it is interesting to note the great value of jaborandi. We have in this remarkable drug a new agent of vast power for the relief of such symptoms. After the operation, there was not the least sign of any return of pericardial effusion, and, although it is probable that adhesions have formed, there are no evidences at present that the heart's action is embarrassed by them. So far as the original disease is concerned, it may be said that a complete cure was effected. The subsequent attacks of subacute peritonitis and of plastic pleurisy indicate a constitutional character for all of the successive affections of the serous membranes, and I fear that it may prove that they have been tuberculous.

I have narrated this case in great detail, because the operation of paracentesis of the pericardium must still be considered as a debatable subject. It was only natural that, with the vast extension lately given to the performance of paracentesis thoracis, an increased amount of attention should be bestowed upon the former operation. Nor is it surprising, when we recall the widely different views held as to the conditions suitable for paracentesis thoracis, and as to the advantages to be hoped for from that operation, to find a very wide diversity of opinion as to the propriety and mode of performance of paracentesis of the pericardium. I shall not dwell upon the history or statistics of this latter operation, because it happens that very recently these points have been made the subject of able and exhaustive memoirs.[1]

I may mention, however, that Roberts has collected forty cases,[2] and that since the date of his publication three others had been reported,[3] which, with my own case, brings up the total number to forty-four. Of these, only four have been in America. The first of these was operated on by Dr. J. C. Warren, in 1852, and Dr. H. H. Smith (*Syst. of Surgery*, vol. ii. p. 307) who quotes the case, states that he learned, on personal inquiry from Dr. Warren, that the patient recovered sufficiently to leave the hospital in a few weeks, after which he was not heard of. The second operation was performed by Dr. Lyon in 1874 (*loc. cit.*). The case was one of pericarditis with purulent effusion, secondary to pneumonia; paracentesis was performed twice, at intervals of seven days, but death occurred on the sixteenth day after the first operation. The third was by Dr. Welch (*loc. cit.*), and also terminated fatally in a few days. I have already shown that the case attributed to Dr. Bowditch never occurred, so that the operation I have above described is the fourth instance in this country, and the second in which the operation has been followed by success.

I have long been satisfied, upon theoretical grounds as well as from a knowledge of the results of the operation in those cases where it has been performed, that paracentesis of the pericardium is justified, and even imperatively demanded under certain conditions. Thus, of the 44 cases on record, 20 may be regarded as successful—a rate of mortality of about 55 per cent. It must be remembered, too, that in all of these cases the operation was performed when the patient was almost moribund; and, moreover, that, in the large majority, the pericarditis was either part of a general and incurable disease, or else was complicated by the coexistence of some other serious affection. Under no circumstances has the operation, if properly performed, been productive of any injurious effects; even in the most hopelessly unfavourable cases it has afforded great relief; while, if regard be had only to the comparatively uncomplicated cases, the ratio of complete and lasting recoveries is very high—certainly not less than 60 to 65 per cent. It must be admitted, therefore, I think, that paracentesis pericardii is a justifiable operation; and it consequently becomes very important to determine under what circumstances its performance is called for, and what is the best method of operation. I shall try to show you that, if a correct diagnosis of extensive pericardial effusion has been made, the operation itself is attended with but little difficulty or danger; and, consequently, the primary indication for paracentesis may be stated to be a liquid effusion in the pericardial sac, which has not yielded to a thorough employment of other modes of treatment, and which is causing such grave disturbances of circulation and respiration as to urgently threaten life. It is impossible to define the amount of effusion which may cause such symptoms, and thus call for operative interference. In cases where it has been formed gradually, enormous quantities (one, two, or even four quarts) of liquid may be tolerated with fewer grave symptoms than are often caused by twelve or sixteen ounces which have been suddenly effused. Again, the effect produced by a certain amount of liquid will vary greatly in accordance with the amount of plastic exudation associated, with the condition of the muscular fibre of the heart, and with the absence or presence of pulmonary complications. Equally is it impossible to define the length of time that the operation may be delayed. In many cases even of very large effusion the symptoms, though severe, are not so urgent as to demand operative interference, and ample opportunity is thus afforded for the successful employment of milder means of treatment. In regard to this point, indeed, very much the same rules should guide us as in cases of pleural effusions. It is too much the habit of late years, since paracentesis has been rendered so easy of performance, to speak as though every case of pleural effusion called for the operation; while, in fact, although the operation is invaluable under suitable conditions, a large proportion of all such cases will do well, if not better, without it. So in cases of pericardial effusion, if the symptoms satisfy us that the liquid is purulent, we cannot operate too soon; if a large serous effusion exists, and has resisted all other means of treatment for several weeks, the operation should be performed to avoid the serious injury that may result to the heart from prolonged compression; finally, if an effusion, even of moderate extent, be productive of symptoms of urgent danger to life, the operation should not be deferred.

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[1] H. Roger—Bull. de l'Acad., vol. xl., 1875, pp. 1202 and 1259. J. B. Roberts—New York Med. Journ. 1876, p. 585. Trousseau—Clinical Med., Syd. Soc. ed., vol. iii. p. 364.

[2] Dr. Roberts gives forty-one cases in his table, but he includes one by Dr. Bowditch, which is reported in Trousseau's Clinical Medicine. I learn, however, on personal inquiry from Dr. Bowditch, that he never performed the operation.

[3] Lyon—New York Medical Record, April 1, 1876, p. 221, from Med. Comm. of the Connecticut Med. Soc., 1875. Welch—American Journal Med. Sciences, Jan. 1877, p. 190, published in Trans. of Iowa State Medical Society. Hunt—London Lancet, March, 1877.

You will, of course, perceive that at the basis of these practical rules lies the question of an accurate diagnosis. Fortunately, in the vast majority of cases, this can be made without serious difficulty. It is indeed true that errors in diagnosis have been made even by skillful and experienced observers; but in such cases it will be found that very unusual complications or anomalous conditions existed. Certainly, if the case is an acute one, and has been under observation while the effusion formed, an accurate diagnosis can readily be made. Nearly always there will have been a friction sound of cardiac rhythm, and this may persist, especially about the base, even after considerable increase in præcordial dulness from effusion has been developed. Then, carefully repeated percussion will show at first extension of dulness about the base of the heart, but soon this will be followed by a change in the shape of the area of dulness, which assumes a rudely triangular form with its base downwards, together with a decided extension of the area. If percussion be practised both when the patient is in the sitting and in the recumbent position, scarcely any difference will be observed in the horizontal level of the dulness, but if the patient be turned first to one side and then to the other, it will often be found that the area of dulness, without changing its shape, has some mobility from side to side. The position of the apex-beat of the heart will also be observed to change as the effusion occurs; it becomes raised more and more, and then becomes lost, though sometimes an obscure sense of shock can be felt over the præcordia after a distinct cardiac impulse can no longer be detected. The sounds of the heart become markedly feeble, distant, and obscure; and the centre of their greatest intensity may be observed to vary from its normal position. In addition, there may be found, in cases of very large effusion, prominence of the præcordia, slight bulging of the intercostal spaces over the heart, and even fluctuation on palpation. If the case has been under observation from the beginning, and careful attention has been paid to the above signs, a large pericardial effusion can scarcely escape detection—unless, indeed, there should coexist pleurisy with effusion on both sides, or on the left side alone. In this event it would probably be impossible to decide as to the presence or absence of pericardial effusion until the liquid had been withdrawn from the left pleural sac by aspiration. If the combined effusions were not sufficiently extensive to cause symptoms demanding operative interference, the ordinary treatment for pleurisy would suffice; while if such symptoms did appear, as in all probability they would, it would be proper to tap the pleural sac first, after which the pericardial effusion could be easily recognized, and treated as seemed appropriate. The cases where the greatest difficulty occurs in the diagnosis of pericardial effusions are those which come under observation only after the disease has lasted some time. Here we could scarcely expect to find friction-sounds, and we would be without the valuable aid furnished by observing the progressive changes in the extent and shape of the area of dulness, and in the position of the apex-beat. We must then rely upon the prominence of the præcordia; the enlarged triangle of dulness, with its base below; the absence or altered position of the apex-beat; the distant and feeble character of the heart-sounds; the displacement of the anterior border of the lungs; and the extreme disturbance of circulation and respiration. It is true that an enlarged and dilated heart has been mistaken, and has even been tapped, in mistake, for a distended pericardial sac. But a searching investigation into the history of the case—the fact that the apex-beat, however feeble, is on the lowest level of præcordial dulness—the shape of the area of dulness, which here also is triangular, but with its base upward and to the right; and the character of the heart-sounds, which, though feeble, are much less distant and obscure than in large pericardial effusions—all of these will combine to enable a correct diagnosis to be made. Again, a solid, mediastinal tumour has been mistaken for a distended pericardium; but I am confident that close attention to the diagnostic points I have given would prevent the commission of this error I would gladly dwell longer on this vital question, but I have only time to allude to the practical details of the operation itself. Having determined the presence of pericardial effusion, and having decided that the urgency of the symptoms demand operative interference, you must determine upon the mode of operation, and the point at which the puncture shall be made. I shall not even mention the various modes of operation that have been recommended and practised, because I think it is beyond doubt that the safest and best method is by means of Dieulafoy's aspirating syringe, or vacuum jar. Having created a vacuum either in the jar or in the syringe, the needle is connected with it by a piece of rubber tubing; the skin is drawn from below upwards over the point selected for puncture, and the needle is then firmly pressed into the tissues. It is well to apply ice to the surface for a couple of minutes beforehand, so as to lessen pain; and if the skin is very thick, a short incision may be made through the derm to facilitate the passage of the needle. As soon as the eye of the needle is completely covered by the flesh, communication with the vacuum is opened by turning a valve or stopcock. The needle is then deliberately pressed forwards until fluid is seen to pass suddenly through the little glass index in the tube, and to enter the jar or the syringe. The needle to be used is either the smallest or the next to the smallest size. The point at which the puncture should be made has been the subject of much discussion. Of course, we desire to enter the pericardium where it is most distended with liquid, and where there is least danger of wounding the heart. Experiment and post-mortem observation have shown that in cases of large pericardial effusion the line of greatest distension of the sac is about the fifth rib; and as the apex of the heart is invariably displaced in such cases, no safer or better point of puncture can be selected than that of the normal apex-beat, *i. e.*, in the fifth interspace, about midway between the left border of the sternum and the left nipple-line. The internal mammary artery lies nearer to the sternum, and thus is in no danger of being wounded. In order to make sure of entering the pericardial sac, the point of the needle may be directed slightly upwards and inwards; or, if the effusion is evidently very large, immediately backwards. As soon as fluid is reached, the point should be turned outwards and downwards so as to lessen the risk of the heart coming in contact with it. If the precautions I have mentioned are observed, the point of the needle may, it is true, touch the apex of the heart, but it cannot be imbedded in it, nor inflict any serious injury. In order to still further diminish this danger, I have had made a delicate double canula, the inner tube being furnished with a fine needle point. The movements of the inner tube are regulated by a button which moves along a slot in the outer tube. This canula may be introduced with the inner tube projecting, and then, as soon as the pericardial sac is entered, the sharp point is withdrawn, and we have only an ordinary blunt-pointed canula, from which no injury to the heart is to be apprehended. If, after introducing the canula to a reasonable distance, its point still feels imbedded in solid tissue, and no fluid escapes, it is probable that extensive plastic exudation exists, or that the effusion is sacculated. The canula should be withdrawn, and a second attempt may be made at a neighbouring point, or in the fourth interspace. If, after a certain amount of fluid has escaped, it begins to be largely mixed with blood, the canula should be withdrawn promptly, as the hemorrhage probably comes from the delicate new vessels of organized false membranes. If the effusion proves to be purulent, I should advise the withdrawal of as much as will flow freely, and then the injection of dilute solution of iodine; after which the canula should be withdrawn. I cannot conceive that the introduction of a drainage-tube would prove useful, or be well tolerated. I would much prefer the performance of a second paracentesis later if the pus re-accumulate.

The operation of paracentesis of the pericardium must be regarded, therefore, as a comparatively simple and safe one in cases where an accurate diagnosis of large pericardial effusion has been made. It is not likely to be followed by any unfavourable results. The effusion may collect again, but I do not believe that it would be more likely to be purulent on account of the operation having been performed. If it does not collect again, as in the case here reported, there will probably be close pericardial adhesions; but this would equally have resulted if the effusion had been removed by absorption. I feel, therefore, that a consideration of the operation itself, as well as of its results in this case, and in the other cases on record, justifies the rules I have suggested to you in regard to its performance.

HOSPITAL NOTES AND GLEANINGS.

Gout and Rheumatism.—In a recent clinic at the London Hospital, Mr. HUTCHINSON made the following remarks on gout and rheumatism: If a man has had a sudden swelling of the great toe, with great pain, œdema, and glossiness of skin, disappearing in ten or fourteen days, you may be sure that man has had an attack of gout. The reason why it attacks the great toe (joint) is because this is the most abused joint in the body. Even when it begins to be painful, one goes on using it. The swellings of joints in gout are soft. Probably the deposit which is found here (lithate of soda) is thrown down during the inflammation. Garrod thinks it is deposited first, then excites inflammation. However this may be, if you cut into such a joint afterwards, you find the abnormal condition. Cartilage may be ulcerated away; this is rheumatic. Now, gouty people are generally rheumatic—*i. e.*, they inherit the rheumatic (arthritic) tendency (for rheumatism is very hereditary). But the reverse does not hold—*i. e.*, rheumatic people are not necessarily gouty; the gout is something superadded to the rheumatic diathesis. It is dyspeptic; it means mal-assimilation; it has to do with stomach, liver, and kidneys. When a gouty subject has an arthritic (*i. e.*, a rheumatic) tendency, his gout will manifest itself in the joints; if otherwise, his joints may escape, and he may suffer only from dyspepsia, neuralgia, etc. On the other hand, give a rheumatic subject diseased kidneys, and he will very likely have gout. We see, then, that gout is in relation to the kidneys, or more generally speaking, is in relation to increase of waste matter (nitrogenous and saline in the blood). Hence gout does not necessarily mean diseased kidneys. It may first be the result of altered living, or of growing old and taking consequently little exercise. Rheumatism and gout are so intimately connected, that if the subject of gout has not had rheumatism, probably his relations have. In both there must be a predisposition before some exciting cause (such as a blow on the knee in gouty synovitis, or exposure to cold in rheumatic fever) causes a manifestation of it, just as a blow on the leg will cause a node in a syphilitic subject. Rheumatism is more a nervous disease than a hæmic one. The lactic acid theory is very conjectural; it is more likely due to some spinal condition causing a multiple arthritis. The rheumatic diathesis, then, means a condition of nervous system which is highly susceptible to weather and external circumstances. It is therefore climatic. Gout, on the other hand, is dietetic, and is to be treated accordingly. Gout is frequently attended by disease of the vessels, and there is always a liability to their rupture. Hence red patches on the conjunctiva from ecchymoses, and epistaxis, are not uncommon in gout. A certain kind of retinitis, called hemorrhagic, and characterized by numerous effusions all over the retina, each one being flame-shaped, is quite pathognomonic of gout.—*Med. Times and Gaz.*, Jan. 19, 1878.

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Case of Lacerated Wound of the Knee-joint treated successfully by Lister's Method.—Charles W——, aged fourteen, was admitted on August 20th, 1877, into the Queen's Hospital, Birmingham, under Mr. West's care, suffering from a lacerated wound of the right knee-joint, produced by getting between some cog-wheels. The wound was on the outer side of the joint, and was about four inches long and two inches broad. The tissues around were considerably contused. The joint was opened, and two fingers could be introduced into it.

The patient was suffering from considerable shock; the hemorrhage was not severe. The wound was washed out with a solution of carbolic acid, one to ten, and dressed with Lister's antiseptic dressing, five silver sutures being used to bring the lacerated skin as far as possible into apposition. A straight splint and an extension apparatus were applied to immobilize the limb. The wound was dressed antiseptically every day for a month, and the discharge from it continued perfectly sweet throughout, although all the contused tissues sloughed and came away. No unfavourable symptoms occurred, and the temperature, with the exception of the first two days, when it reached 100° F., remained normal, as did also the pulse and respiration.

On Sept. 28th the wound was so small and superficial that the antiseptic dressing was discontinued, and red wash used. It was then healing rapidly, was quite superficial, and was not larger than one inch by half an inch. The splint was still used, and the limb kept completely at rest. The joint was perfectly normal in size, there being no synovitis, and the outline of it was quite as distinct as that of the sound side. The patient did not complain of any pain whatever, and he ate and drank well. He could slightly flex the knee when the splint was taken off.

On Oct. 20th the wound had perfectly healed and no dressing was applied. The patient got up for the first time. He could walk very well, but the knee was kept stiff, although, when he sat down, he could flex it almost completely. There was no bony or fibrous anchylosis whatever.

Remarks by Mr. West.—This case is noteworthy from the absence of any constitutional disturbance after so severe an injury. Not many years ago, amputation would have been performed, so fatal was considered to be a wound of so large a joint. More especially is the case remarkable from the fact of the wound having been a lacerated one, and one in which there was more likelihood of constitutional disturbance than if the wound had been clean cut. By the adoption of the antiseptic treatment, although the lacerated tissues of a necessity sloughed and came away, so producing considerable discharge; yet there was no smell of decomposition, but everything remained perfectly antiseptic throughout; and, from my own experience, it is in these lacerated wounds that Lister's treatment is of such very great service. The fact of there being no anchylosis, either fibrous or bony, justifies me in saying that the lad will have the perfect use of his limb.—*Lancet*, Dec. 22, 1877.

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Glycerine of Carbolic Acid as a Dressing after Ovariotomy.—Dr. THORBURN, Obstetric Physician to the Royal Infirmary, Manchester, mentions (*Med. Times and Gaz.*, Dec. 15, 1877), a plan of dressing the wound and pedicle after the operation of ovariotomy, which he had recently adopted with marked success. The pedicle having been secured by the carbolized catgut ligature, and divided, the stump and ligature are freely smeared with the glycerine of carbolic acid of the Pharmacopœia, and returned within the abdomen. The edges of the abdominal wound, including the peritoneum, are treated in a similar manner before the wire sutures are tightened, a pad of lint soaked in the carbolized glycerine is placed over the wound and secured by a bandage, and the parts are not disturbed for ten days. Twenty-five cases of ovariotomy have been thus dealt with, and though six of the cases died, in none of the six could the fatal result be attributed, in the least degree, to septicæmia. In no instance had there been any purulent or other discharge, or any inflammatory exudation in the track of the sutures. Dr. Thorburn contended that by thus trusting the wounded parts to the undisturbed influence of the carbolized glycerine for many days, he puts to more practical proof his faith in the antiseptic virtues of carbolic acid than do those operators who examine the condition of the wound so much more frequently.

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Transfusion in Uterine Hemorrhage.—Dr. ROSSI relates (*Annali Universali di Med.*, Dec.) the case of a woman thirty-two years of age, to whom he was called on account of profuse hemorrhage coming on on the eighteenth day after delivery. In several prior labours she had uterine hemorrhage; but in the present one all had gone on well until now, although she was in a very weakly condition. The os uteri was found to be too close to admit the finger, and hypodermic injection of ergotine and plugging were resorted to. The hemorrhage ceased temporarily, but her state of collapse became so fearful that the only doubt as to the propriety of employing transfusion was whether she was not too far gone to resort to it. However, it was resolved upon, and about 150 grammes of lamb's defibrinated blood were injected. Great reaction ensued, and after this had subsided, on a vaginal examination, a portion of placenta, the size of a crown-piece, was extracted with some difficulty. The patient eventually did well.—*Med. Times and Gaz.*, Jan. 19, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Dialyzed Iron as an Antidote in Arsenical Poisoning.—Mr. RICHARD V. MATTISON has recently been investigating the value of dialyzed iron as an antidote to arsenic. He concludes (*Phila. Med. Times*, Jan. 5, 1878):—

1. That dialyzed iron, to be of value as an arsenical antidote, must be first precipitated by the action of some neutral or alkaline salt.

2. That this precipitation and the consequent production of ferric hydrate are accomplished when this preparation is taken into the stomach; and that, therefore,

3. The solution of dialyzed iron is a valuable antidote for arsenical poisoning, and should be administered promptly in cases of emergency as a temporary antidote, followed of course by emetics.

Now, it may readily be conceived that an antidote may be necessary in cases where the enfeebled stomach of the invalid may not be able to secrete sufficient gastric juice to precipitate the iron, even under the stimulus of the poison, or that the arsenic may be ingested into a healthy stomach entirely free from any gastric secretion.

While under these circumstances the secretion of mucus would perhaps prevent absorption for a certain length of time, yet in these cases, and indeed I believe in *all* cases, the administration of dialyzed iron as an antidote for arsenical poisoning should be followed immediately by a teaspoonful or more of common salt, thus insuring the formation of the ferric hydrate and the consequent neutralization of the poison. This should at once be followed by an emetic, as the action of the ferric hydrate on the arsenic is not to coagulate it, but to form a perfectly definite chemical salt known as the arsenite of iron (ferric arsenite), which, although practically insoluble, is far from being harmless.

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Death from Chloroform.—A young lady residing on Staten Island recently died, who had been put under chloroform and after five teeth had been extracted gave signs of recovering and was then put under chloroform again. Immediately after she was taken with a spasm; the dentist attempted to complete his work, but was compelled to desist and make an effort to save her life, but it was not successful. A post-mortem examination showed all the organs to be healthy.

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New York State Medical Society.—The seventy-second annual meeting of this Society was convened at Albany, January 15th, Vice-President, Dr. A. L. Saunders, of Madison Co., in the chair. The attendance was good, and a number of valuable papers were presented. The following officers were elected for the ensuing year: President, Dr. D. B. St. John Roosa, of New York; Vice-President, Dr. Judson C. Nelson, of Truxton, Cortland Co.; Secretary, Dr. Wm. Manlius Smith, of Manlius, Onondaga Co.

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Medical Society of Virginia.—The eighth annual session of this Society was held at Petersburg, Oct. 23d, 24th, and 25th, Dr. James L. Cabell, of University of Virginia, President, in the chair. Eighty-four members were registered as in attendance. Dr. Withers, on behalf of the profession of Petersburg, extended a cordial welcome to the Society. A number of interesting reports on the progress of medicine were read as well as several scientific papers. The following officers were elected for the ensuing year. President, Dr. J. Herbert Claiborne, of Petersburg; Vice-Presidents, Drs. Wiley, of Salem, Godwin, of Fincastle, Parrish, of Portsmouth, Randolph, of Charlottesville, Love, of Winchester, and Wellford, of Richmond; Secretary, Dr. Landon B. Edwards. The next meeting will be held at Richmond.

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Louisiana State Medical Association.—A Medical Convention convened in New Orleans on the 14th of January last, to organize a State Medical Association. Dr. S. M. Bemiss, of New Orleans, was elected temporary chairman. The roll of parishes was called, and fifteen parishes were represented by eighty delegates, and the Louisiana State Medical Association was declared organized. Dr. J. C. Egan, of Caddo, was elected Chairman. Drs. S. M. Bemiss, of New Orleans, J. W. Dupree, of East Baton Rouge, G. A. B. Hays, of Plaquemines, Vice-Presidents. Dr. Thomas Layton, of New Orleans, Secretary. Dr. Geo. K. Pratt, of New Orleans, Treasurer. Seven delegates were elected to the American Medical Association. The next meeting will be held in New Orleans on the second Wednesday of April, 1879.

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Advertisement of Medical Certificates of Nostrums, etc.—The Comitia Minora of the Medical Society of the County of New York have adopted the following:—

Resolved, That for a physician to permit the use of his name, or professional reputation, in commendation of any drug, medicine, wine, mineral water, nostrum, proprietary article, or medical preparation, or of any surgical instrument or appliance whatsoever, for the purpose of advancing the pecuniary interest of any inventor, patentee, originator, discoverer, manufacturer, proprietor, or advertiser of such article or appliance, is an unworthy act.

Also, that for a physician to publish, or allow to be published in the journals, public prints, or other publications intended for the use of the laity, reports of medical or surgical cases, or papers on medical or surgical subjects, for the purpose of attracting the attention of the general public to the author, is repugnant to the high sense of honour that should govern the medical profession.

These are the devices commonly resorted to by quacks and impostors, and have for their end the attainment of fame and notoriety by other means than those efforts in the line of professional duty which are the honourable physician's only legitimate paths to advancement in the confidence and patronage of the public.

In view of the foregoing resolutions, whereas, it has come to the notice of this Committee that certain waters—known as Apollinaris and Hunyadi Janos—also certain wines and other medical articles, are extensively advertised in the public journals and by handbills throughout the country;

And, whereas, the names of certain members of this Society appear in connection with medical certificates in said advertisements;

And, whereas, such action is in plain violation of the letter and spirit of the Code of Ethics as well as of the foregoing resolution of this Committee:

Therefore,

Resolved, That the gentlemen whose names appear on said certificates be requested to withdraw or cause the withdrawal of their names and certificates from said advertisements.—*Medical Record*, Feb. 2, 1878.

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Medical Department of Harvard University.—President Eliot in his annual report states that the medical school has cleared, in the past three years, more than twenty-five thousand dollars over and above its expenses, which is to be reserved for future contingencies, but hereafter the annual surplus will be applied to increase the moderate salaries of the professors. Attention is called to the fact that the percentage of matriculants holding scientific degrees has risen from twenty-three per cent., which it was seven years ago, to forty-four per cent.

Preliminary examinations were held for the first time last year, and out of forty-two candidates who presented themselves twenty-seven were admitted without conditions, seven with conditions, and eight were rejected. The total number of students in attendance during the past year was 247.

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New Medical Journals. — The *Detroit Lancet* succeeds the *Detroit Medical Journal*, and Dr. Leartus Connor associates with himself Dr. H. A. Cleland in the editorial management.

Michigan Medical News is a semi-monthly journal published at Detroit under the editorial management of Dr. J. J. Mulheron. The first number was issued on the 21st of January, and contains twelve pages of original and selected matter.

The Arkansas Medical Record is a sixteen page monthly, which is published at Little Rock, and edited by James I. Hale, M.D.

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Editorial Changes. — Dr. Galt, of the *Louisville Medical News*, has retired from the editorial chair, in which he was associated with Dr Cowling, and Dr. L. P. Yandell, Jr., succeeds him.

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Obituary Record.—At Louisville, Feb 4th, of pneumonia, Lunsford P. Yandell, M.D., aged 73 years.

Dr. Yandell was a native of Tennessee, he obtained his medical degree at the University of Maryland, in 1825. In 1831, he was elected to the chair of Chemistry in the Transylvania University and subsequently, at different times, held the chairs of Chemistry, of Materia Medica, and of Physiology in the University of Louisville. He was at one time editor of the Transylvania Journal of Medicine and afterward of the Western Journal of Medicine. He was the author of the address on "Medical Literature," delivered before the International Medical Congress. At the time of his death he was completing a "History of Kentucky Medicine."

FOREIGN INTELLIGENCE.

Digitalis as a Diuretic.—M. Hérard, during a discussion at the Société de Thérapeutique (*Journal de Thérap*, Jan. 1), stated that he administered digitalis after maceration, this being by far the best mode. He macerates twenty-five centigrammes of coarsely powdered leaves in 200 grammes of *cold* water for twelve hours, and carefully strains. This is given in five or six doses, at a distance from meals, is usually very well tolerated, producing no nausea or gastralgia, and can be continued for five or six days, or longer. This twenty-five grammes should rarely be exceeded, as experience has taught him, having formerly employed much larger quantities. Given in this way the effects are often marvellous, a powerful diuresis ensuing, during which from six to ten litres of urine may be passed in the twenty-four hours, the patients being resuscitated, as it were, into a comparatively good condition. M. Bucquoy said that he preferred M. Hérard's old dose of seventy-five centigrammes, suspending the medicine at the end of four days; but M. Moutard-Martin has, like M. Hérard, diminished the doses he formerly prescribed.—*Med. Times and Gaz.*, Jan. 19, 1878.

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Abortive Treatment of Furunculus.—Dr. Lieven observed at the Petersburg Medical Society (*Petersburg Med. Woch.*, Dec. 29) that all modes of treatment hitherto tried (such as early incision, cauterizing, and cold or warm applications) have failed to arrest the further development of furunculus that has once commenced. The following procedure, however, brings it to a stand: A burning, pricking, itching, suddenly occurring in a normal portion of the skin, announces the commencement of the development of the furunculus, and on the same day a small and quite superficial induration can be felt at the spot. If the skin be now superficially scraped with a small knife, so that a drop or two of blood may be pressed through the epidermis, no furunculus will be developed. This result would seem to show that the affection originates in the uppermost layer of the corium, and perhaps in the capillaries of the papillæ, and not, as hitherto received, in the subcutaneous connective tissue, with succeeding necrosis of the corium and epidermis. Disturbance of the digestive organs (frequently diarrhœa) always precedes or accompanies furunculus; but a plethoric or decrepit constitution is no necessary condition, as it may occur in one that is quite normal.—*Med. Times and Gaz.*, Jan. 19, 1878.

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Injection of Perchloride of Iron in Uterine Hemorrhage.—In a recent discussion at the Obstetrical Society of London on the value of injection of chloride of iron in uterine hemorrhage, Dr. Robert Barnes said the point of the syringe should be carried to the fundus. This could only be insured by introducing the hand into the uterus. Clots should be removed before injecting. One to four is a good strength, but a stronger solution might be used if necessary, but it should not be escharotic. This means of arresting hemorrhage had stood the test of experience, and had saved many lives. The test for its use is the possibility of exciting reflex action. Where this cannot be done, use perchloride of iron.—*Med. Times and Gaz.*, Jan. 19, 1878.

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Camphor-Chloral.—Mr. W. T. Tocher recommends the following formula for a camphor-chloral liniment, which has a powerful antineuralgic application: Chloral-hydrate and camphor, of each one ounce; glycerine, to six ounces; powder the camphor, using as usual a few drops of rectified spirit; then mix with the chloral, and allow to stand in a mortar until the mixture becomes liquid. Having poured this into a bottle, add the glycerine, and shake.—*London Med. Record*, Jan. 15, 1878.

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Inodorous Iodoform.—Ether dissolves iodoform, and removes its disagreeable odour. If the solution be applied to a surface the ether soon evaporates, leaving behind a uniform layer of iodoform.—*Amer. Practitioner*, Jan. 1878, from *Gazette Obstetricale.*

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Typhoid Fever and Milk Supply.—The *Lancet* (Jan. 19, 1878) gives the following particulars in reference to the outbreak of typhoid fever in Glasgow:—

In the first week of the new year it

was rumoured that typhoid fever had suddenly become prevalent in the west end of Glasgow, and that the source of infection was the milk supply of certain dairies. One or two deaths in prominent social circles intensified anxiety and made people suspicious of milk from any quarter. Inquiries subsequently begun by the sanitary staff of Glasgow allayed alarm, by localizing the contaminated milk supply to two large dairies. Though these circumstances were known, it was reserved for Dr. Russell conclusively to embody various speculations in a singularly exhaustive report, which has been presented to the Health Committee of the Town Council. He has shown that the two dairies in question were fed by a constant supply of milk from a farm where typhoid fever has existed since 1st December, "that the sanitary arrangements of this dairy were particularly defective, that the excreta of the patients were emptied into a 'grip' —*i. e.*, a channel running on each side of the central passage provided in byres for the reception of cattle droppings." A forcing bed was thus prepared for the further development of the typhoid contagion from the heat and moisture of the other byre excreta. The water in which the various dairy utensils were washed was chiefly obtained from a well to which the contaminated sewage had percolated. Portions of this water are in the hands of the city analyst, but his report has not yet been issued. It has been ascertained at present that forty-nine cases of fever have existed among the customers of the dairies in question. Among the number of those infected were seven students who drank the milk at the refreshment room of the University, and out of these, three have already died. The facts thus ascertained by Dr. Russell, and the melancholy details attached to the fever propagation, will, it is to be hoped, lead to the proper and periodic inspection of town dairies and their country feeders. It is not pleasant to think that disease may be unwittingly brought to the doorstep every morning, through the simple medium of the most essential of all nourishing fluids for family use.

Danger of Children's Parties.—Dr. JOHN WHITMORE, Medical Officer of Health, in his report on the health of the parish of St. Marylebone, adds a note upon the danger of children's parties in disseminating infectious diseases, notably whooping-cough, and he gives an illustration which lately came under his notice. A lady recently gave a children's party at which some fifteen or sixteen were present; amongst them was a little boy who was observed to cough violently, and who it was afterwards ascertained was suffering from whooping-cough. Of all the children present on that occasion, it is already known that twelve have taken the disease, as well as two nursemaids who were in attendance, and two of the cases have proved fatal. Dr. Whitmore makes some opportune remarks on the mischief caused by the popular belief that whooping-cough is not infectious as well as contagious, and says that it is undoubtedly both, and therefore all children suffering from it should be isolated from others that are healthy. We confess to a strong suspicion that an erroneous belief is by no means always the innocent, because ignorant, cause of such occurrences as that commented on by Dr. Whitmore. We have met with mothers not at all scrupulous about letting their own children risk being infection-carriers rather than lose an evening's amusement, though the very slightest risk of their becoming infection-receivers through like conduct of other mothers would excite displays of temper unknown to the repose that stamps the caste of Vere de Vere.—*Med. Times and Gaz.*, Jan. 19, 1878.

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A Now Living Double Monster.—In the *Wiener Med. Wochenschrift* for Dec. 8, Prof. HESCHL furnishes the description of an examination he has made at Vienna of a living girl, seventeen years of age, who exhibits an example of a still rarer form of monstrosity than the Siamese Twins or the Two-headed Nightingale, inasmuch as in her case the formation, in place of the upper part of the body being double as in their cases, consists in a doubling of it only below the second lumbar vertebræ, the upper portion resembling that of a pleasing delicate girl of from ten to twelve years of age. The case is a specimen of Förster's *Dipygus tetrapus.*—*Med. Times and Gaz.*, Jan. 19, 1878.

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Death from Chloroform.—Another case of this is recorded in the *British Medical Journal* for Feb. 2.

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Death from Chloral.—In the same journal there is reported a case of death from self-administration of an overdose of chloral.

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Chloral Hydrate a "poison." — The Council of the British Pharmaceutical Society passed a resolution that chloral hydrate and its preparations ought to be regarded as poisons within the meaning of the Pharmacy Act. This has received the approval of the Lords of the Privy Council, and since the 14th of January it has been illegal in Great Britain for unregistered persons to sell chloral hydrate or its preparations, and it is unlawful for any persons to sell them unless the box, vessel, wrapper, or cover containing them are distinctly labelled with the name of the article and the word "poison."

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Telephonic Auscultation.—According to the *Medical Press and Circular* the telephone has been successfully used in auscultation. It is quite possible that it may become a valuable means for class demonstration.

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Cause of Death of Victor Emanuel.—The proximate cause of King Victor Emanuel's death was asphyxia, due to the complete arrest, from red hepatization, of the function of the right lung, the function of the left having already been impaired by the same malady. As in most of such diseases when contracted under the "malarial cachexia," there was a copious sudaminous eruption, the "miliary fever" of the Italian text-books. But this rather relieved than aggravated the symptoms, and left the cause of death, as has been stated—asphyxia. The inhalation of oxygen, which was practised at the close, was intended to mitigate the august patient's sufferings, which by that time had become extreme.

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OBITUARY RECORD.—At Dublin on the 7th of January, aged 74 years, **WILLIAM STOKES**, M.D., F.R.S.

Dr. Stokes was the most distinguished ornament of Irish medicine. He was for fifty years physician to the Meath Hospital, and of the knowledge which he gained in that position he gave liberally to the profession. He was the author of *Lectures on the Theory and Practice of Medicine*, *of Diagnosis and Treatment of Diseases of the Chest*, of a classical *Treatise on the Diseases of the Heart and Aorta*, and recently of a volume of *Lectures on Fever* which was reprinted in the Library Department of this journal, as well as of a number of contributions to various journals, etc.

—— at London, on the 15th of January, aged 87, Dr. **JAMES BLUNDELL**, formerly Professor of Obstetricy at Guy's Hospital. Dr. Blundell was for many years a famous accoucheur and the author of a well-known work on Midwifery, published in 1834.

—— at Paris, on the 18th of January, aged ninety years, **ANTOINE CÉSAR BECQUEREL**, Professor of Physics at the Museum of Natural History.

—— at Auteuil on the 19th of January, in the sixty-eighth year of his age, **HENRI VICTOR REGNAULT**, Professor of Physics at the College of France, and of Chemistry at the Polytechnic School. M. Regnault was the author of an elaborate work on Chemistry.

—— at Ardtrea Rectory, County Tyrone, Ireland, on January 31, aged 70 years, **FLEETWOOD CHURCHILL**, M D., the late distinguished Professor of Midwifery in the School of Physic of the University of Dublin, and ex-President of the King and Queen's College of Physicians. Dr. Churchill's works on "Theory and Practice of Midwifery," on the "Diseases of Women," and on the "Diseases of Children" were for a quarter of a century standard text-books on the subjects of which they treated.

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Surgeon Extraordinary to Her Majesty, the Queen, etc.

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It is entirely unnecessary for us to attempt to add, by our praises, one jot to the established reputation of Erichsen's Science and Art of Surgery. It has long been a favorite text-book and authority in this country as well as in England and on the Continent, and the present edition can but add to its popularity.—*Ohio Medical Recorder*, Jan. 1878.

In revising this standard work, it will be seen that the author has spared no pains to make it worthy of a continuance of the marked favor which it has so long enjoyed, by bringing it thoroughly up to the advance in the science and art of surgery. There are about 309 pages added to the text, and about 200 wood-cuts added to the illustrations. It will maintain its position as a text-book of the medical student, and a reference book for the practitioner.—*St. Louis Med. and Surg. Journal*, Feb. 1878.

The announcement that a new edition of Erichsen's Surgery has been issued will be received with intense pleasure by all lovers of the art. The treatise, from one end to the other, has been thoroughly and conscientiously revised by its renowned author. Matter which had become obsolete in the swift advance of surgery has been left out, whole chapters have been rewritten, and every modern improvement in the art of surgery has been noted. One hundred and fifty new wood-cuts also add to the usefulness of the work in its present shape.—*Louisville Med. News*, Feb. 16, 1878.

Mr. Erichsen is already familiarly known either personally, or as an eminent authority, by nearly every American surgeon; and his statement that he has spared no effort to bring his work to the present state of our knowledge, needs no indorsement.—*New Remedies*, Feb. 1878.

HENRY C. LEA—Philadelphia.

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CLINICAL LECTURES.

ON SPONDYLITIS RESULTING IN CARIES OF THE SPINE.

A Clinical Lecture delivered at the Bellevue Hospital, New York.

BY LEWIS A. SAYRE, M.D.,
Professor of Orthopedic Surgery and Clinical Surgery in the Bellevue Hospital Medical College.

(Phonographically reported, especially for the Medical News and Library, by M. Josiah Roberts, M.D.)

GENTLEMEN: To-day we have some cases of spondylitis resulting in caries of the spine, called also Pott's disease, because it was first accurately described by Percival Pott, who died in 1788. But it is no more proper to call the disease which we are to consider to-day Pott's disease than to group the various affections of the kidneys, differing in causation, treatment, and prognosis, under the comprehensive title of *Bright's Disease of the Kidneys;* for, though Pott and Bright were the first to write systematically upon the diseases which their respective names bear, yet neither of them possessed anything like the amount of definite knowledge in regard to their etiology, pathology, course, treatment, and termination, which is known at the present time. Although we would give Bright all the glory which is due to him as the first systematic writer upon diseases of the kidneys, yet we do not think this should entitle a number of diseases, the existence and na-

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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ture of which he was entirely ignorant, to bear his name. So, too, with Pott's disease, which we would prefer to call spondylitis—and which, unless arrested, results in caries of the spine. It ought to go by the name of Pott's disease no longer. The title, spondylitis, describes to some extent the nature of the disease in question, and hence is preferable to a title which gives no idea of the structures involved or the pathological changes which take place.

Spondylitis may occur at any period of life, as the result of falls, wrenches, strains, or other traumatisms to the spinal column, or its attachments.

A blow or concussion may cause an extravasation under the interarticular cartilages, this extravasation remaining undetected until continued muscular exertion develops an inflammation which goes on to softening and disintegration. Suppuration may take place, and the imprisoned pus give rise to a great deal of pain; but the most important point is, that the nutrition of the interarticular cartilages becomes interfered with, and disintegration, disorganization, or necrosis takes place on account of the very low degree of vitality of the involved parts.

Another way in which the disease may be produced is by the individual receiving a fall or a blow of such a nature as to cause the fracture of some one of the vertebral processes. As you know, a vertebra, in its early organization, consists of seven distinct points of ossification, each of which increases in growth until further along in life, when they become consolidated into a single bony mass. Now, some little blow to the part may be sufficient to set up an inflammatory action in some one of these ossific centres, or interfere with their nutrition, and thus lead to complete disintegration of the bony structures.

Another way in which the disease may be produced, is by the bending of the spinal column out of its normal position by the strong muscles attached to the bodies and processes of the vertebræ, as in the case of a wrench, where the powerful contraction of these muscles might pull up the periosteum and thus give rise to a periosteal inflammation.

Another way is by the compression of the ribs, thus driving the heads of the ribs against the articular facets so forcibly as to set up an inflammation which may result in carious degeneration.

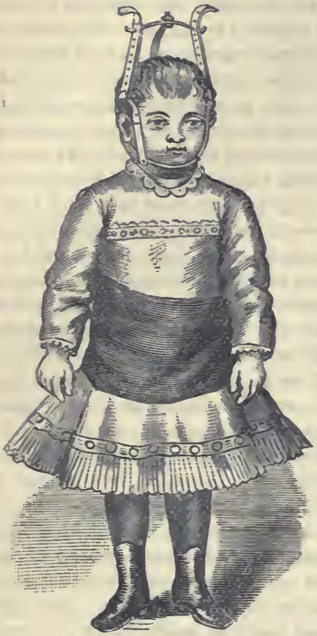
But no matter what may be the cause of spondylitis, the symptoms which are characteristic of the disease are generally slow in their development, and sometimes require months before they speak out with sufficient distinctness to be recognized as peculiar to the disease under consideration. One of the earliest symptoms of the disease is due to the fact that the nerves given off from the spinal cord at points in close proximity to those implicated in the degenerative changes in the vertebræ become involved to a greater or less extent, the evidences of which are manifest at their *distal* extremities. For example, if the disease be in the neck, before there is any evidence of distortion, the patient will have a choking cough, difficulty in swallowing, thoracic pains, etc., which may lead one to think there is some disease of the larynx, trachea, or lungs.

A patient was presented to you a few weeks ago, if you remember, suffering from paralysis of the lower extremities, caused by spondylitis in the cervical vertebra, but who had been for several months treated as a case of croupous laryngitis, and finally the physicians in charge decided to perform tracheotomy, for the purpose of removing a foreign body, supposed to be in the larynx. But prior to the intended operation I was called in consultation, and by simply lifting the child's head so as to remove the superimposed weight from the diseased vertebræ, respiration became normal. By the adjustment of an apparatus to retain the head in this position (see fig 1 from Photograph by Mason), the child was made perfectly comfortable, as you remember, and I have since received the following favourable report from her parents, dated Hot Springs, Arkansas, November 14th, 1877:—

"Her health is greatly improved, and

she romps about the premises all day long, as merry as a cricket. No nervous irritation. *no cough* nor lassitude, but a sunny, rollicking tomboy."

Fig 1.



And you all remember that, previous to the adjustment of the support, she was paralyzed in her lower extremities, and her peculiar cough was incessant.

Further down the spine the disease gives rise to palpitations of the heart, pain in the lower part of the chest, and a sensation of constriction.

The disease occurring still further down the column, the patient may have symptoms of gastritis, and receive at the hands of a physician, who fails to detect the true nature of the disease, a course of treatment for dyspepsia.

Occurring further down, the intestines may become involved, and all the symptoms of worms develop, the case being treated accordingly, no suspicion arising that a portion of the spinal column is diseased, until an abnormal prominence of it occurs at some point.

Lower still, the disease may give rise to pain in the bladder, rectum, and thighs, yet no suspicion arises as to the true nature of the disease until deformity occurs. A frequent desire to urinate is a common symptom of the disease in this portion of the vertebræ long before deformity is manifest.

So, when you find the symptoms we have enumerated present in any particular case, examine your patient carefully, and if you find no evidences of disease in the larynx, lungs, heart, liver, or digestive organs, then look to the back. Watch the child as he walks, and see if he moves with that freedom and elasticity so characteristic of childhood. If spondylitis be developing, the child walks in a careful manner, the muscles of the trunk are kept rigid to prevent any movement of the vertebræ upon each other, the joints of the lower extremities are in a state of partial flexion, to prevent any jar upon the vertebral column, the shoulders elevated, the chin projected, and every possible means taken to relieve the inflamed parts from pressure or movement. If the child be asked to pick up an article from the floor, he will simultaneously bend his hips, knees, and ankles, and thus by *squatting* reach the article, instead of *bending* over as a well child would do, his object being to prevent any movement of the spinal vertebræ. You then ask the child to raise himself upon his toes and come suddenly down upon his heels, watching to see whether he keeps his limbs straight or bends them to relieve concussion. The instant you see such actions as these, take off the clothes and examine the back. For this purpose, after the clothes have been removed, lay the child across your lap, face down, legs on one side of your thigh, and arms over the other thigh; gradually separate your limbs, in order to extend the spinal column and remove pressure from the inflamed parts.

I neglected to state that in this disease the peculiar respiration is a prominent and important symptom: it is short and grunting in character. When the child is placed over your thighs, and the spine extended, he will take a deep, full, and comfortable inspiration; it is the sigh of relief, as I call it. Should you approximate your thighs, and thus admit of pressure upon the nerves and inflamed parts, the child will have a spasm, and resume the same short, grunting respiration. If spasm does not follow upon the removal of the extending force, it, together with pain, may be produced by placing one hand upon the child's head and the other over the sacrum, and crowding the spinal column together.

You may press upon the spinous processes and get no pain, especially is this the case if the anterior portions of the bodies of the vertebræ be the seat of the degenerative changes; for pressure upon the spinous processes will tend to remove pressure from the diseased parts by separating the anterior portions of the bodies of the vertebræ, and thus relief, instead of pain, is given. You may examine the spinal column in this way and find no evidence of pain, and you say there is no disease. Do not be too sure of this, for it frequently happens that the disease does not begin on the anterior portion of the bodies of the vertebræ, but upon the sides of the vertebræ at their junction with the ribs; therefore, in order to ascertain whether this be the case or not, take each rib separately and crowd it against the vertebræ with which it articulates. By taking the ribs separately and driving them against their articulating surfaces, if disease exist at this point, you will elicit pain together with reflex spasm, and at the same time ascertain the exact situation of the diseased parts.

Treatment.—The treatment has been to place these patients in bed and confine them in the horizontal posture. This is beneficial treatment, in so far as it removes pressure from the inflamed parts, thus decreasing the tendency to softening, degeneration, and absorption; but it does not prevent reflex muscular contraction, unless there is combined with it extension and counter-extension; hence patients who recover from the disease without the use of extension recover with more or less distortion due to muscular contraction, even when they have been treated by keeping them constantly in the horizontal position.

But the confinement in the horizontal position for so many months, is injurious to the health of the patient, and hence numerous braces have been devised, the most popular of which is the one contrived by Dr. Taylor, of this city, and which you see adjusted to the little girl before you. This brace consists of an iron pelvis-belt, which is connected with two upright bars that make pressure along either side of the spinous processes, but do not press upon the processes themselves. The most important feature of the instrument is the hinge-joint movement on a level with the diseased vertebræ, thus permitting the superimposed weight, sustained by the upper portion of the spinal column, to be transferred from the anterior portion of the bodies of the vertebræ to the posterior portion and the transverse processes.

Case 1. This little girl when six years old received a fall, soon after which she began to have pain in the back, and was immediately sent to an institution for treatment. A brace was placed upon her, there being no distortion at the time, as her mother says, and she has worn it constantly ever since, a period of nearly four years, until now she is in the condition in which you see her. You will observe that the bands which pass around the thorax compress the chest in such a manner that the difficulty of breathing is greater than in any plaster-of-Paris jacket when properly applied.

When we apply a plaster-of-Paris jacket, we first expand the chest to its fullest capacity by suspending the patients from the head and armpits, and then require them to take a full inspiration; thus by the action of the levatores costarum and the intercostals, the ribs are separated to the fullest possible extent.

The little girl before you, as you see, is bent well backward and held in that position by the brace which she wears, the object being to allow the superimposed weight to fall upon the transverse processes and the posterior part of the bodies of the vertebræ, instead of where it normally does. In this case it is the sixth, seventh, eighth, and ninth dorsal vertebræ which are diseased, and form the prominence. I wish you to observe the excoriation upon each side of this prominence: The pressure of the instrument upon the sides of the projecting vertebræ has interfered with the nutrition of the parts, and that is one great reason why recovery does not take place. I have used this sort of a brace for many years, and it has been my experience that, if the patients recover while wearing it, they recover with more or less distortion. In order to remove pressure from the sloughing sores, I take thick pieces of felt and place them upon either side, as you see, and thus guard against cutting off any nutrition to the diseased parts from undue pressure. I have a skin-fitting knit shirt placed over the patient before the plaster bandage is applied. This shirt is without sleeves, and is secured in position by tabs tied over the shoulder. Beneath the shirt in front, in the epigastric region, we place a stomach or dinner-pad, which is removed when the plaster gets partially dry, and thus room is left beneath the plaster jacket for the ingestion of a hearty meal of victuals.

This child has never been swung up before, so we will have to instruct her as to the various steps of the process. As she raises herself by means of the pulley-rope, you see we do not permit her to bend the elbow, and pull down, but simply place one hand above the other, and continue this climbing process till she has raised the weight of her body from the floor, and simply touches the latter with the tips of her toes. This gives rise to no pain whatever, and the deformity which has resulted from the disease gradually becomes less conspicuous, as you see, due to the removal of the superimposed weight from above, and the force of gravity acting upon the dependent portion of the body below.

We will now apply the bandages, which have been prepared of cross-barred muslin or crinoline torn in strips from two or three inches wide, according to the size of the patient, and about three yards long, the meshes of which have been rubbed full of finely ground plaster-of-Paris and rolled up in the form of an ordinary roller-bandage. These are to be dipped, just previous to being used, into a basin of warm water, sufficiently deep to completely immerse the rollers when set into it upon their ends. If the bandage be put in on its side, the air cannot escape, and the inner portion of the roller will not be sufficiently saturated with water to make it easy of application. When the air has ceased to escape from a roller, it is then perfectly saturated and fit for use, and should be applied at once. As you take one roller from the basin, squeeze it gently to expel the surplus water, and immerse another end-wise, which will be sufficiently saturated for application by the time you have applied the first. Never place two rollers in the water at the same time.

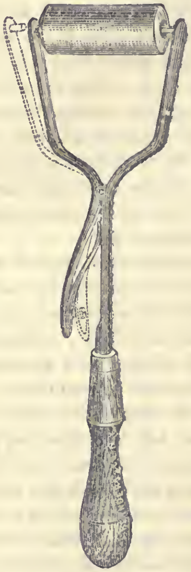
The thickness of the jacket to be applied depends upon the size of the patient, three to five layers usually being sufficient for an ordinary sized child, but for an adult of large size probably more thicknesses would be required.

Now you see the chest is fully expanded, and, as my assistant applies the plaster bandage, I press the layers together and see that it fits the body snugly at all points, pressing it into the intercostal spaces and all other sinuosities, being careful not to make undue pressure over any elevations or projecting points. You perceive that our little patient holds herself in position by means of the pulley-rope with perfect ease, and she has just told me that she is entirely free from pain. Having covered the trunk with two layers of the plaster bandage, we now place narrow strips of tin, roughened on either side like a nutmeg grater, vertically around the trunk three or four inches apart, and carry another wet plaster bandage over these, which materially increases the strength of the casing without adding to its weight.

Having completed the application of the bandage, we now hasten the setting of the plaster by running up and down it with this heated iron roller. This idea was suggested to me by an Irish lady when I was in Ireland, where the atmosphere is so moist as to materially interfere with the setting of the plaster; but the ordinary triangular iron found in houses proved to be so inconvenient that

I had Mr. Reynders make this form of an instrument, which looks very much like a miniature garden roller. When the iron roller gets cool, it can easily be changed for a hot one.*

Fig. 2.



We will now lay her upon the table until she gets partially dry; but before the drying process is completed, it is important to remove the dinner-pad, and, having withdrawn it, to press the bandage in the inguinal region, thus widening it out over the anterior and superior processes of the ilium. Should the spinous processes project too prominently, it is a wise plan to place a pad over them before beginning the application of the bandage. The pads should project below the casing, so that they can be easily removed when the plaster has set. We will cut out a piece of this little girl's jacket directly over the excoriation on her back, and through the opening thus made apply some unguents; probably the next time she has a jacket adjusted to her, this will be unnecessary.

Should there be any pain experienced after the application of the jacket, no matter how slight, it is due to the fact that the bandage has been improperly applied; therefore it should be *removed at once* and a new one applied, for there is something wrong. If this be neglected, there is great danger of excoriation as a consequence of undue pressure upon certain parts.

Sometimes very young children will cry when suspended for the purpose of applying the plaster jacket, but the cry of pain can be easily differentiated from that of fear or obstinacy. When their crying is not due to pain, you can proceed with your work with no fear of making undue compression of the thorax, and thus interfere with the pulmonary circulation.

Case II. This patient has suffered from spondylitis for six or seven years, and, as you see, has an enormous curve. I cannot say whether we will be able to help this patient or not, until we have suspended him in order to see whether the curve of his back is lessened; if so, we may be able to do him some good.

By applying a strip of sheet-lead closely over the curved portion of the spine, before he is suspended, removing this, placing it edgewise upon paper, and tracing its outline with a lead-pencil, we get an exact representation of the spinal curvature. Now, suspend your patient, straighten your strip of lead, and apply as before; remove, trace its outline alongside the first, and you have a mathematically accurate representation of the decrease, if there be any, in the spinal curvature. Those patients who recover from this disease could, with timely and proper treatment, just as well recover without distortion as with it. Should a patient come to you with partial or complete consolidation, you will under no circumstances be justified in attempts to completely rectify the deformity. The vertebræ in this case are very nearly anchylosed, for you see the child is able to stand without support while I am putting on his shirt; frequently the pain is so great that the patient is unable to stand, and we are obliged to put his shirt on while he is in the horizontal position.

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* I have since discovered that the plaster hardens more readily by blowing on it with a pair of bellows.

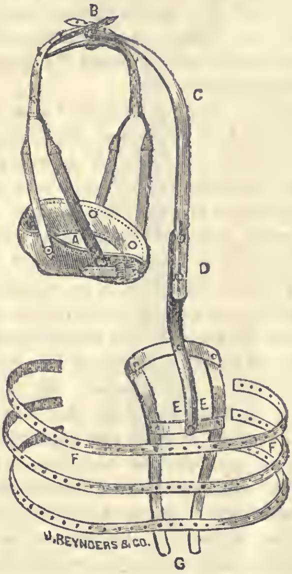
We have now ascertained the degree of curvature, both before and after suspension, and you observe what a marked diminution in the curve has taken place. Now, if we succeed in retaining this patient's spine in a position with no more curvature than it has while he is suspended, recovery will take place with very much less deformity than he now has, and it will take place much more rapidly. We will apply the plaster bandage in the same manner as in the previous case.

After an individual, suffering from spondylitis, has been placed in a properly applied plaster-of-Paris jacket, almost the first change in the appearance of the patient, which you will notice, will be the flush of color to the cheeks and an expression of absolute comfort.

In cases of spondylitis, abscesses are sometimes connected with the diseased vertebræ; and, if so, they may open down upon the thigh, in the rectum, and there is no telling where they may open, even when the disease is high up in the dorsal region or in the cervical region. Should an abscess open in any place where it will be covered by the plaster bandage when it is applied, you should make an opening through the casing so that any desired applications can be made. For this purpose, place a piece of oiled silk over the abscess after a free incision has been made, then draw on the shirt, and, having placed a piece of folded cardboard with a pin projecting through it, over the wound, so as to indicate the position of the abscess, apply the plaster bandage, passing it over the pin, which, projecting, will serve as a land-mark for cutting a fenestra. Now make a circular incision which shall extend through all the layers of the jacket, remove this piece, and when you come down upon the shirt and silk, *star* them and turn the flaps over the cut edges of the opening through the casing, which will leave a clean fenestra leading to the abscess. Put in some Peruvian balsam and oakum or carbolized oil, place a bandage over it and dress it every day. This arrangement is all that could be wished, and does not perceptibly weaken the support, which is so essential in the treatment of these cases. When there are any active inflammatory changes going on within the vertebræ, you will find it much better to retain the casing entire than to divide it. Sometimes, however, after the inflammatory processes have been arrested, and the patient is convalescent, the jacket may be divided in front and islet-hooks placed upon each side, a corset string then being used to retain it in position. Thus modified, a plaster jacket may be removed or applied at pleasure, and it makes a much better corset for support than the ordinary kind.

Case III. The case which I now present to you is one in whom the disease is in the cervical vertebræ. The same principle of treatment is applicable here as in other portions of the spinal column; but the plaster jacket in this instance acts as a support to a jury-mast or head-rest, from which the head is to be suspended. This child, you observe, has his chin resting upon his sternum, his hands upon his knees, and has that grunting respiration so peculiar to this disease. By simply placing one hand under the chin and the other under the occiput, and gently lifting the head, you observe that the jerking respiration ceases at once. We therefore allow the child to suspend himself by the head-rest, having previously put on this skin-fitting shirt and adjusted the dinner-pad, we apply the plaster bandage as in the first instance. Having now covered his entire trunk with two layers of the bandages, we now adjust the jury-mast or head-rest. This, as you see, consists of two parallel, malleable iron bars which go upon either side of the spine, being connected at the top and giving support to a piece which is curved over the head and terminates in a swivel or cross-bar, from which is suspended the leather head-rest supporting the chin and occiput. The two malleable irons upon either side of the spine are capable of being bent to accommodate any curve. Thin strips of tin, one half to one-fourth of an inch in width, and perforated with holes, are attached to the bars, which pass two-thirds of the way around the body. Another layer of plaster bandage is applied over the tin strips and lower portion of the jury-mast, which serves to secure them in position. The upright bar behind has two slots in it, so that it can be moved up and down and secured in any desired position. The result is that the child carries the weight of his head, through the medium of the jury-mast and plaster-jacket, upon his hips.

Fig. 3.



Having completed the application of the bandage, we will now lay the child upon the bed and wait for the plaster to set, after which we will suspend his head from the cross-bar by means of the leather head-rest, taking care to have it sufficiently elevated to give freedom from pain. Having done this, the child will be able to walk about with his head in the ordinary position, free from pain and with an expression of comfort, as seen in Fig. 1.

[The lecture being completed, the first case was measured against the wall, and found to be three-fourths of an inch taller than before the plaster bandage was applied; cheeks more red in colour, and the child perfectly comfortable.

The second case was not so much increased in length, but much improved in position. He stated he was much more comfortable than with any brace he had ever worn.

The third, in whom this disease was in the cervical region, after the head-swing was applied and properly adjusted, ran about the room with perfect freedom, head erect, sustained and supported by the jacket and jury-mast alone, requiring no support from his hands whatever.—REPORTER.]

HOSPITAL NOTES AND GLEANINGS.

Case of Carcinomatous Tumour between the Pharynx and Larnyx.—This patient was a male about sixty years old, and was under the care of Professor **LANGENBECK** at the University Clinic, Berlin. He had suffered from dysphagia, occasional dyspnœa, and hoarseness of voice, of some standing; the first being now chiefly complained of.

On examination, a soft tumour could be felt on the right side of the neck, at the level of the thyroid cartilage, and over the carotid, which communicated a slight heaving impulse to it. The laryngoscope showed that the parts above the vocal cords were inflamed, and the larynx slightly compressed. The epiglottis was healthy. A bougie could be passed down the œsophagus, but with some difficulty.

The patient was put under chloroform, but rapidly became asphyxiated; the pupils were widely dilated, and the face livid. He was restored by artificial respiration. Tracheotomy was performed, and a tampon canula inserted. The head being now bent back, with the neck horizontal, an incision was made on the right side from a point level with the great cornu of the hyoid bone, and about 1½ to 1¾ inches from the median line, extending downwards and slightly inwards for about 4 to 4½ inches. All the muscles which hindered rotation of the hyoid to the left were then cut through in turn, and numerous vessels were ligatured; and a tumour of cauliflower-like appearance was found between the pharynx and larynx. Professor von Langenbeck then removed it with its attachments (having rotated the larynx); viz., half of the cricoid cartilage, partly right, partly posterior; the right arytenoid cartilage; and nearly the whole of the right half of the thyroid, the first and last being ossified.

The tumour was flattened, nearly circular in form, two inches in diameter and rather more than half an inch thick, pale yellow in colour, with a flat toadstool-like pedicle. Microscopically, it was found to be carcinomatous.

The patient went on well for two days; then lung-mischief (pneumonia) appeared, and he sank rapidly, dying on January 13th. No necropsy could be obtained; but Prof. Langenbeck attributed death to the retention in the bronchi of mucus, discharge, etc., which the patient had not the strength to expectorate.

Remarks.—The operation, I believe I am correct in saying, is quite novel in conception. Its execution, though dangerous, was most safely performed. That it was most skilfully performed, it is unnecessary to say. We have, then, the after-danger, say, of accumulation in the bronchi, as in this case, setting up fatal pneumonia, to prevent. Could not this be done by the employment of artificial respiration, giving the patient thus the all-necessary power of expelling this accumulation, which he would not himself possess?—*Brit. Med. Journ.*, February 2, 1878.

A Case of Excision of the Mamma, in which a New Method of Drainage was employed.—Mrs. T——, aged sixty, was admitted into Mr. Bell's ward at the Royal Infirmary, Edinburgh, on December 24, 1877, suffering from scirrhus of the mamma with epithelioma of the nipple. On the 26th inst. Mr. Bell removed the breast under antiseptic precautions, but tried a new plan of drainage, on a principle suggested by Mr. McGill, of Leeds, in the January number of the *Edinburgh Medical Journal*. A piece of drainage tubing about three feet long was used. One end was pierced with holes, laid along the wound, and secured at the upper end by a stitch. The other end was weighted and placed in a six-ounce bottle half full of carbolic lotion (1 to 40). To prevent air from passing in by the side of the tube, it was carefully packed round with pieces of loose gauze. During the next twenty-four hours about five ounces of serum were drained away, and when the dressing was removed only about a fourth of the usual discharge was found on it. The only extra precaution required during dressing was that the tube should be secured by a piece of bandage or a clip, lest any air should pass up it while it was out of the bottle. On the second day after the operation scarcely any discharge was found on the dressing. After this the wound was dressed only every second day, until January 4, when it was found to be almost healed, and was dressed with a strip of boracic lint. The patient was dismissed on January 7, the twelfth day after operation, the wound being quite healed. The temperature and pulse averaged normal.

The advantages claimed for this mode of drainage are: (1) that it prevents tension; (2) that it lessens the amount of discharge on the dressing, thus allowing of fewer dressings; (3) that under favourable circumstances it would do away with dressing the wound, as the bottle need only be emptied and refilled; (4) that it would be a speedy indication of bleeding. The disadvantages are: (1) the difficulty of arranging the dressings so that no air could pass up by the tube; (2) the risk of the tube becoming choked by clots.—*Lancet*, January 26, 1878.

MEDICAL NEWS.

ORIGINAL ARTICLES.

Synchronous Double Amputation of the Feet and Hands. By ALEXANDER W. REESE, M.D., of Warrensburg, Ill.

On the night of June 8, 1875, the thermometer standing at 25° below zero, a deep snow on the ground, the wind directly from the north and blowing a severe gale, George W. V., labourer, æt. forty-one, stout, robust, heavy-set, was ejected from a liquor saloon in a state of intoxication. This took place about 11.30 P. M. The streets were deserted and desolate, and, while stumbling along, he fell over a stone embankment on the south side of the street, and, being unable to help himself, laid there all night. About daylight the succeeding morning, he crawled on his hands and knees across the street, and was found on the steps of a grocery store. He was assisted to his boarding-house, some half mile distant, by a couple of men, walking on his frozen feet between the two. An irregular practitioner was sent for and took charge of the case. He first applied tinct. arnica to the hands and feet, which he subsequently abandoned and substituted therefor charcoal poultices. He prohibited coffee and all other stimulants. Such was the history of the case as detailed when I was called to assume its charge, January 22, 1875, fourteen days from date of the exposure. I found the hands and feet in a state of mortification, the line of demarcation being already pretty well established. This line in the hands ran nearly parallel with the metacarpo-phalangeal articulation, in the feet across the middle of the instep. Amputation was, therefore, inevitable.

On the 26th January, in presence of several physicians of this place, I proceeded to operate. Commencing with the hands, I removed the dead portions at the metacarpo-phalangeal articulation, amputating the thumbs at the first joint, in the hope of saving the first phalanx, thus affording the best chances for prehensile powers in the remaining portions of those useful members of the hands. As the heads of the metacarpal bones were soft, spongy, and much impaired in vitality, I clipped them off with the bone forceps, retrenching them as far as possible in the stumps, in order that a good and sufficient covering might be obtained.

As soon as this was completed the feet were removed at the metatarso-phalangeal articulation. The patient bore the operation well, refusing the aid of chloroform. There was but little hemorrhage, and, after a drink of whiskey and half a grain sulph. morph., the wounds were dressed and he was left to "pleasant dreams."

This patient was a good while recovering, from the fact that gangrenous spots on the soles of the feet (including also portions of the heels), above the operation, subsequently made their appearance, sloughed out and healed very slowly. The sloughing on the heels exposed the os calcis to the size of a half dollar. The exposed bones I found to be soft and rotten, and these I chipped off by means of the chisel and mallet. Portions of the soles of the feet also sloughed off, leaving a very tender and red surface. Many scales and spiculæ of bone were exfoliated.

The stumps were daily washed with tepid water and Castile soap, supplemented with a weak solution of carbolic acid. They were then dressed with a covering of patent lint, spread with basilicon ointment or simple cerate.

At the expiration of four months he was able to be on the streets. He is able to handle a knife and fork, keeps a candy and variety stand, and can be daily seen at his post, walking to and from his business place without the aid of crutch or cane.

How this man could have lain out doors on the ground during the greater part of that bitter night without being frozen to death remains a mystery to me. Perhaps the embankment on the north side of him may have contributed in some degree to his escape, by partially protecting him from the icy gale.

DOMESTIC INTELLIGENCE.

Death from Ether and Chloroform.—A case of death from inhalation of a mixture of chloroform and ether is reported in the *Chicago Medical Journal* for March.

Medical Certificates in Daily Papers.—The Committee on Ethics, of the Medical Society of the County of New York, has been officially notified that all the members of the Society who had given certificates regarding the value of certain mineral waters have withdrawn their names from such recommendations in deference to the expressed sense of the Society (see *Medical News*, for March last, page 43).

American Medical Association —The American Medical Association will meet at Buffalo on the 4th of June, under the Presidency of Dr. T. G. Richardson, of New Orleans.

Dr. E. T. Easley, of Little Rock, Arkansas, Secretary of the Section of Anatomy and Surgery, requests that all papers intended for the next meeting be forwarded at least one month before the meeting to the Chairman of the Section, Dr. Henry H. Smith, 1800 Spruce Street, Philadelphia, instead of to his address.

The papers already arranged for this Section are as follows:—

Address by the Chairman, "On Certain Points in the Pathology of the Bones, especially Tubercles."

"On Septicæmia after Resection of Bones," by Dr. Weeks, of Portland, Maine.

"On Disease Germs," by Dr. Watson, of Jersey City.

"On Identity of Hospital Gangrene with Diphtheria," by Dr. Carpenter, of Pottsville, Penna.

"On Tracheotomy without Tubes," by Dr. H. A. Martin, of Boston.

"On an Original Operation for the Relief of Irritation of the Joints in Valgus of the Great Toe," by Dr. Frank H. Hamilton, of New York.

"On Extirpation of the Thyroid Gland," by Dr. Miner, of Buffalo.

"On Pathology and Treatment of Cancer," by Dr. McGraw, of Detroit.

"On Process of Repair of Wounds with and without Antiseptic Treatment," by Dr. Hyde, of Syracuse, N. Y.

"On Fractures near the Wrist," by Dr. Packard, of Philadelphia.

University of California.—We are informed that, with a view of elevating the requirements for graduation and of prolonging the period of study, the same curriculum adopted by the University of Pennsylvania and by Harvard University has been adopted by the University of California. For the present term the preliminary examination for matriculation will be omitted, but it is understood that it will be adopted at no very distant period.

Correction.—In Dr. Pepper's Clinical Lecture on Paracentesis of the Pericardium in the number of this Journal for March, the reference in the foot-note on page 37, to Dr. Welch's case, should have been to the Transactions of the Arkansas State Medical Society.

Medical Graduates in 1878.—

University of Pennsylvania	127
Jefferson Medical College	203
University of the City of New York	153
Bellevue Hospital Medical College	130
Coll. of Phys. and Surgeons, N. Y.	169
Buffalo Medical College	42
Medical College of Ohio	102
Cincinnati Medical College	33
Miami Medical College, Cin.	51
Louisville Hospital Med. College	17
University of Louisville	71
Louisville Medical College	70
Missouri Medical College	102
St. Louis Medical College	49
Medical College of Virginia	12
College of Physicians and Surgeons, Indianapolis	41
Indiana Medical College	29

OBITUARY RECORD.—At Washington, D. C., on the 11th of March, aged sixty-one, CORNELIUS BOYLE, M.D., late Vice-President of the Medical Association of the District of Columbia.

—— At New Orleans, on the 10th of January, AUGUSTUS A. CENAS, M.D., Emeritus Professor of Obstetrics and Diseases of Women and Children in the University of Louisiana.

—— At Toronto, on the 20th of February, aged sixty-seven, EDWARD M. HODDER, M.D., Professor of Obstetrics in Trinity College Medical School, Toronto. Dr. Hodder was a prominent practitioner, and the acknowledged leader of the profession in Toronto.

FOREIGN INTELLIGENCE.

Sudden Death in Typhoid Fever.—M. Dieulafoy has recently published some interesting remarks on sudden death in certain cases of typhoid fever of moderate intensity. This regretable accident is not connected in these cases with any cerebral affection, for the patient remains free from cerebral symptoms during life, and the autopsy does not reveal any trace of cerebral disorganization. Some congestion of the lungs or lobular pneumonia may exist, but these are insufficient to account for the accident. Besides, the sudden onset and rapid progress of the final event point to death from syncope. We have to seek, then, for the causes of this syncope. Does it depend, as some think, on alterations in the muscular structure of the heart, or is it, as others affirm, unconnected with cardiac disease? The former support their theory on the consideration that typhoid patients are subject to changes in the muscular system, particularly to hyaline degeneration, which may have a tendency to affect certain muscles, but does not always spare the heart. This theory, however, though based on a certain number of clinical and pathological facts, does not bear scrutiny, for the cardiac degeneration alluded to is not discovered in a considerable number of cases. Besides, we not infrequently observe that patients labouring under disease of the cardiac valves may live for years despite the degeneration of the muscular tissue of the heart? M. Dieulafoy's explanation of sudden death during the course of typhoid fever is mainly founded on two facts—sudden death may occur independently of typhoid from apparently insignificant causes, such as drinking iced water, cauterizing the œsophagus, etc.; and also on the experiments of Brown-Séquard, Goltz, and Berhein, which demonstrate the special excitability of the intestinal canal, and the mechanism of fainting produced by intestinal irritation. M. Dieulafoy hence concludes that the fatal syncope of typhoid fever depends on reflex action from some point of irritation in the intestines. The irritation is transmitted along the centripetal filaments of the sympathetic nerve to the cells of the spinal marrow and bulb. Here a transformation into movement takes place, and is propagated in different directions; sometimes along the pneumogastric nerve, occasionally producing sudden death; in other cases the respiratory nerves are involved, when respiration and cardiac motions are at once arrested; in other cases we have convulsions terminating fatally. MM. Laveran and Bussand attribute the fatal attack to cerebral anæmia; but M. Dieulafoy asks, if such be the case, how can we explain why patients are not cut off in the same manner during the course of various cachectic diseases, as chlorosis, etc.? Finally, M. Dieulafoy refutes the opinion of some physicians who attribute the fatal event to some sudden change of posture. Were such the cause, it would be imprudent, as he observes, to allow a typhoid patient to make the most ordinary movement, as the result might be instantaneous dissolution.—*Med. Examiner*, February 28, 1878.

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Dialyzed Iron.—Professor Bouchardat having often had his opinion asked as to the nature and therapeutical value of this, communicates a paper to the *Bulletin de Thérap.* (January 30), in which he furnishes an analysis of the best account that has been published of the preparation of dialyzed iron, as given by Prof. Depaire, of the Brussels University, in the *Journal de Méd de Bruxelles* for 1877. As to its therapeutical value, he agrees with Prof. Depaire that, *à priori*, it is not to be expected to be considerable. He himself firmly believes that the salts of iron at the maximum are of very inferior efficacy to that of porphyrized metallic iron—or, better still, Quevenne's iron (which he employs daily), or the preparation of carbonate of iron combined with an organic acid. *Theoretically*, he must regard the dialyzed iron as an inert ferruginous preparation, or as one of the least active, unless clinical observation clearly shows that he is wrong.—*Med. Times and Gaz.*, March 1, 1878.

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Corns.—In a lecture at the St. Louis, on hypertrophy of the epidermis, M. GUIBOUT (*Gaz. des Hôp.*, Feb. 7) observed that, while in callosities the hypertrophy takes place at the surface, in corns the hypertrophied part becomes pyramidal, and takes the form of a nail with its point directed towards the deeper-seated parts. This sharp point, lodged in a kind of cupola, which exactly boxes it in, has a tendency to penetrate into the substance of the dermis whenever the base of the corn is compressed. The portion of the dermis which is in permanent contact with the epidermic induration becomes inflamed and altered in character, its papillæ disappearing, so that at last it becomes a true matrix, destined to form deep new horny epidermic layers in proportion as the more superficial layers are eliminated. Changes of the weather often give rise to great pain in corns, which has been supposed to be due to their hygrometric nature, which, by causing their enlargement, adds to the suffering. But, in fact, the exacerbations are less severe during the time that it rains than they are for some days preceding; and they are also met when the weather is about to change from wet to dry. These painful exacerbations of the pain of corns are quite as remarkable and as inexplicable as are those of rheumatic pains. The sole efficacious treatment is excision, but care must be taken that this is complete. The summit of the cone must be cut down to, so as to entirely empty the dermic cupola. And then it is quite necessary to destroy by cauterization the inner surface of this cupola—*i. e.*, the matrix of the corn—which will otherwise be reproduced. The best caustic is sulphuric acid, of which we may deposit a drop by a match or glass rod on the excised part. If the corn recurs, the same processes of excision and cauterization must again be resorted to. —*Med. Times and Gaz.*, March 9, 1878.

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Alcohol Dressings in Wounds of the Scalp.—Prof. Gosselin, in a recent clinical lecture (*Gaz. des Hôp.*, August 2), called attention to a patient with an extensive contused superficial wound of the scalp, unaccompanied by detachment or denudation. He did so because it was an example of the rapid healing of such wounds which has been so frequently observed under dressing with pure alcohol, without the development of any diffused or erysipelatous inflammation. The rapid cicatrization that takes place is not the result of healing by the first intention, for the edges of the wound still remain a little apart, while the lips and bottom of the wound give issue to sanguinolent seropurulent secretion in nowise resembling good pus. This secretion gradually ceases and the wound becomes dry without ever having been covered with granulations. This instance is a good example of the cases which have for some time attracted Prof. Gosselin's attention, in which wounds are healed by this intermediate mechanism, which is neither immediate cicatrization nor cicatrization after granulation and suppuration. This mode of cicatrization in wounds of the head especially occurs when these are dressed with pure alcohol; other modes of dressing requiring the formation of granulations for healing. Whatever this dressing may be with regard to other parts of the body, in wounds of the head it seems to be that which gives the patient the most protection from consecutive accidents and leads to the quickest cicatrization. So treated, these wounds have less tendency to inflammation and suppuration, are cured quickly, and are less often attended with erysipelas and phlegmonous inflammation.—*Practitioner*, March, 1878.

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The Liquefaction of the Gases of Air and Water.—Apart from the telephone, the liquefaction of oxygen, nitrogen, and hydrogen is, beyond doubt, the greatest scientific triumph of the past year, one of the greatest, indeed, obtained for many years. It is true that this triumph has long been looked for. Since the immortal researches of Faraday few have doubted that the gaseous state is dependent solely on certain conditions of heat and pressure. The experiments of Dr. Andrews, led up to, as they were, by the long neglected ones of Cagnard de la Tour, showed that no absolute line of distinction could be drawn between the liquid and gaseous states. In another research, Andrews found that oxygen, when exposed to very great pressure, contracted more rapidly than the law of Boyle required, indicating, as he did not fail to remark, that it was near its point of condensation. But still the fact remains that until the close of the old year several gases had resisted all pressure brought to bear upon them, and that for them theory remained unverified. The mechanical difficulties to be overcome were enormous, and the expense to be incurred very great, the last consideration having, it is to be feared, barred the way for years. It is not a little curious that a mechanical problem, at once so difficult and so important, should have been solved independently almost at the same time by two different workers, and by two different methods. As far as oxygen goes the glory must certainly be shared by M. Cailletet, of Paris, and M. Pictet, of Geneva.

It is not possible within our narrow limits to describe in detail the methods employed by the two workers. M. Cailletet's apparatus is simple enough in theory. Without using any very intense cold, he compresses the gas enormously by mechanical means, and then allows it to expand suddenly at a jet. The cold produced by this expansion is sufficient to liquefy a part of the element, while the rest flies off into the atmosphere. M. Pictet's apparatus is far more elaborate. He begins with a store of liquefied sulphurous acid gas. This is used in a second chamber to liquefy carbonic acid gas, and this in a third chamber to liquefy oxygen. The oxygen is generated from chlorate of potash, in an exceedingly strong iron cylinder. A tube from this cylinder passes through the solid carbonic acid, and terminates in a stopcock, which can be opened when the pressure has become sufficient. Four powerful pumps and a 15-horse-power engine are employed to carry the vapours of the sulphurous and carbonic acids through the chambers which are to be cooled by them, and it is not necessary to add that the mechanism is of the most perfect kind.

Experiments with the now visible elements are progressing rapidly, and we may expect, ere long, to hear of their properties in the new condition. The study of their densities, their appearance, and their chemical activities will be certain to reveal many marvellous facts, and to throw light on many doubtful points. What will happen, for instance, when liquid oxygen and hydrogen meet?—*Lancet*, Jan. 19, 1878.

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Dr. Althaus's Paper on Acute Anterior Myelitis in the Adult.—At the annual general meeting of the Medical Society of London, held on the 4th of March, the silver medal of the Society, given to the author of the best paper read during the session, was awarded to Dr. Julius Althaus, for his paper on "Acute Anterior Myelitis in the Adult," which he has contributed in full to the current (April) number of *The American Journal of the Medical Sciences.*

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International Medical Congress of 1879.—It has been determined to hold the sixth session of the International Medical Congress at Amsterdam, in September, 1879. A committee, of which Professor Donders, of Utrecht, is President, has been formed to make the necessary arrangements.

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The Milk Epidemic of Typhoid Fever in Glasgow.—Now that this epidemic (see *Medical News* for March, 1878, p. 45) is virtually at an end, Mr. Russell has reported the actual extent and fatality of it. In this report are only included cases which have actually been traced to infection by the suspected milk, and they amount to 163 in all. The death-rate was comparatively low, about 9.2 per cent., or 15 in all.

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Death from Chloroform.—A case of this occurred at the Liverpool Northern Hospital on the 7th of February.—*Med. Times and Gaz.*, Feb. 16, 1878.

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Obituary Record.—At Paris, on the 10th of February, Claude Bernard, aged sixty-five years.

Claude Bernard was born at Saint Julien, a small village near Lyons, on the 12th of July, 1813. After he had obtained his early education he was apprenticed to a pharmacien; afterwards he devoted himself to literature and wrote a vaudeville, which was performed at Lyons. In 1834 he went to Paris with a new tragedy in five acts, which he showed to Saint-Marc Girardin, the famous academician, to whom he had a letter of introduction. He, however, urged Bernard to abandon letters and tragedy writing, and to study science. He thereupon entered himself as a student of medicine, and in 1839 became an inmate of the hospitals. In 1841 Magendie laid the foundation of his subsequent career by appointing him his assistant in the laboratory of the Collége de France. In 1843 Bernard sustained his thesis on the gastric juice and took the degree of Doctor of Medicine.

His tastes were as strong for practical surgery as for experimental physiology, and it was not until 1853, when he took with great *éclat* the degree of Doctor of Science at the Sorbonne, that he finally decided to devote himself to the latter. Honours now began to flow rapidly in upon him. In 1854 he was called to the Chair of General Physiology at the Sorbonne, and in the same year he was elected to the Academy of Sciences, Section of Medicine and Surgery. In 1855 he succeeded Magendie in the Chair of Experimental Physiology at the Collége de France. In 1867 he succeeded Flourens in the French Academy, and entered the Museum of Natural History as Professor of General Physiology. He was made a Commander of the Legion of Honour, and in 1869 he was appointed a Senator of the Realm. The Institute and the Academy of Medicine likewise elected him to membership, and the Society of Biology made him their perpetual president.

Claude Bernard was attacked in December last with grave vesical trouble, and on the 10th of February he succumbed to a pyelo-nephritis with uræmic complications.

The Government, in recognition of the great service he had rendered to science, decreed that his funeral should be held at the expense of the State. He was buried with military honours on the 16th of February at the cemetery of Père-Lachaise. The funeral was attended by representatives of learned societies from all parts of France. Discourses were pronounced at the grave by M. Dumas in the name of the Superior Council of Public Instruction; M. Mézières, in the name of the French Academy; M. Bouillaud and M. Vulpian, in the name of the Academy of Sciences; M. Laboulaye, in the name of the College of France; M. Paul Bert, in the name of the Faculty of Sciences of Paris; M. Gervais, in the name of the Museum of Natural History; M. Moreau, in the name of the Academy of Medicine, and M. Dumontpallier, in the name of the Society of Biology.

In the death of Claude Bernard science has lost one of her most distinguished representatives, and France a most illustrious son. He was universally conceded to be the greatest physiologist of his time. His influence was felt wherever physiology was cultivated, and his name will descend to remote posterity. His discoveries of the function of the pancreas, of the glycogenic function of the liver, his experiments upon the production of diabetes by puncture of the floor of the fourth ventricle, his researches upon the influence of the great sympathetic upon innervation of the bloodvessels, and those upon the colorification, upon the salivary glands and upon poisons and drugs, with many others, have immortalized his name. His scientific work is comprised, save in a single volume, in his courses delivered at the College of France, which have been from time to time published. His writings are universally known and appreciated, and are true models of experimental inquiry.

——— At Paris, on the 15th of February, of apoplexy, **Leon-Clément Voillemier**, Commander of the Legion of Honour, member of the Académie de Médicine, and Agrégé of the Faculté

M. Voillemier was a surgical author of considerable reputation, and his name is well known in connection with his writings on dislocation of the wrist, fracture of the lower end of the radius, capillary puncture in abscess, the treatment of urethro-perineal fistula, and diseases of the urinary organs.

——— At Bayswater, on Jan. 27, **Charles Ritchie**, M D. Dr. Ritchie is best known by his researches on the Physiology of the Ovary, published in the *London Medical Gazette*, 1843–5, in which he maintained that ovulation was independent of menstruation.

——— At Leipzig, on Jan. 26, aged 83, **Ernst Heinrich Weber**, the distinguished physiologist.

PLAYFAIR'S MIDWIFERY—Just Issued.

A TREATISE ON THE SCIENCE AND PRACTICE OF MIDWIFERY.

By W. S. PLAYFAIR, M.D., F.R.C.P.,
Professor of Obstetric Medicine in King's College, etc.

In one handsome octavo volume of 576 *pp., with* 166 *illustrations: cloth,* $4; *leather,* $5.

Considering the short time that has elapsed since its appearance, Dr. Playfair's treatise has become extremely popular with medical practitioners and students. In many medical schools it has been adopted as the "Manual of Midwifery" *par excellence*. This position it owes chiefly to its own intrinsic merits, but also to the fact that it is at once the production of one of our metropolitan professors and the most recent work representing the progress that has been made in the art and science of midwifery during the last quarter of a century. It is written in a clear, practical, and comprehensive style. This is just the class of book that has long been needed for the student and practitioner alike, and we feel that it thoroughly merits the success which it has already met with.—*London Med. Examiner*, Sept. 6, 1877.

The high reputation already won by Dr. Playfair in this special department of medicine, is a sufficient guarantee for the meritorious character of this work. Every page is replete with interesting and instructive matter, containing the very latest information regarding the subject of obstetrics, full of hints of the greatest practical value. The book is profusely illustrated with valuable wood-cuts, and is printed in beautiful type.—*Cincinnati Lancet and Observer*, Nov. 1876.

He has been happy in producing the pleasantest, and most readable, and withal, for its size, the most instructive book on obstetrics of recent years.—*Am. Journ of Obstetrics*, Jan. 1877.

These volumes will, from the honest purpose of their author, and the ability of their execution, at once take a position in the highest rank of obstetric works, and must prove a most useful guide in this most onerous and responsible branch of the profession.—*London Lancet*, June 24, 1876.

Dr. Playfair has produced an admirable book. Few works on Obstetrics we have enjoyed the reading of so much as this. We predict for "Playfair" no ordinary success.—*Am. Practitioner*, Oct. 1876.

Not only an excellent epitome of the science and practice of Obstetrics, but one which presents to the student most of the recent advance in that branch of medical knowledge.—*Boston Med. and Surg. Journal*, Oct. 19, 1876.

The two text-books on Obstetric Medicine which hold the first place in the present day are Dr. Playfair's *Treatise on the Science and Practice of Midwifery*, and Dr Leishman's *System of Midwifery*. Every student should have one or the other of these. —*London Med. Record*, Sept. 15, 1877.

This is a well arranged and concisely written, compact manual, in which the science and art of obstetrics is presented in a very comprehensive and systematic manner. It is saying everything else for it to remark that it is thoroughly up to the requirements of the times, and is destined to be one of the most useful handbooks in that department. It is profusely illustrated and well printed.—*N. Y. Med. Record*, Dec. 30, 1876.

LEISHMAN'S MIDWIFERY—Second Edition—Just Issued.

A SYSTEM OF MIDWIFERY:

INCLUDING PREGNANCY AND THE PUERPERAL STATE.

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The best of recent English text-books.—Robert Barnes in *Am. Journ. of Obstetrics*, Jan. 1878.

That this book is recommended as a text-book by many of the leading scholars of medicine in this country, is sufficient evidence of the favor in which it is held. In a word, we know of no better book in our language, both for the student and practitioner. The value of the book is enhanced by this second edition, which contains many notes by our late Dr. Parry.—*Chicago Med. Journ and Examiner*, March, 1877.

This new edition decidedly confirms the opinion which we expressed of the first edition of the work, in the May, 1874, number of this Journal, that this is, the best modern work on the subject in the English language." The excellent practical notes contributed by Dr. Parry refer principally to the use of the forceps, lactation, and the puerperal diseases, and are intended to increase the usefulness of the work in this country. An entirely new chapter on diphtheria of puerperal wounds has been added (Dr. P. has had unusual experience in this form of puerperal fever), and also a number of illustrations of the principal obstetrical instruments in use in America. We have no hesitation in saying that the work, in its present shape, is a great improvement on its predecessor, and in recommending it as the one obstetrical text-book which we should advise every English speaking practitioner and student to buy.—*Am. Journ. of Obstetrics*, Feb. 1876.

But the most valuable additions to the volume are those made by the American editor. We know no obstetrical work that has anything better on the use of the forceps than that which Dr. Parry has given in this, and no work that has the rational and intelligent views upon lactation with which he has enriched this. Having used "Leishman" for two years as a text-book for students, we can cordially commend it, and are quite satisfied to continue such use now.—*Am. Practitioner*, March, 1876.

HENRY C. LEA, PHILADELPHIA.

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VOL. XXXVI. MAY, 1878. No. 425.

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CLINICAL LECTURES.

MEDICAL CLINICS ON PRACTICAL SUBJECTS.

BY ROBERTS BARTHOLOW, M.D.,
Professor of Theory and Practice of Medicine in Medical College of Ohio.

Delivered at the Good Samaritan Hospital, Cincinnati, Ohio.

(Reported by Fred. Kebler, M.D.)

1. *Disease of the Aortic Orifice; Embolism; Right Hemiplegia.*

GENTLEMEN: The hemiplegic patient before us is only twenty-nine years of age. You are aware, of course, that it is not usual to see so young a man the subject of hemiplegia. Note, also, the mode in which the paralysis came on: three days ago he observed that his arm and leg were getting weak, and in a few hours he was surprised to find that he could not move them at all. There was no sudden stroke, no period of unconsciousness; none of those warnings, indeed, which we are taught to expect in these cases. Now the loss of power is so complete that, when I lift up the arm and let it go suddenly, it drops like a bar of lead. There is, also, considerable diminution of sensibility—of touch, of pain, of temperature; but, doubtless, the function of sensibility will soon be restored, the motor paralysis continuing.

Thus far we learn, merely, that we have to deal with a case of hemiplegia. My duty would be very inadequately discharged, indeed, if I were content to name

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Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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the disease and then pass on to the treatment. I must ascertain the seat and nature of the disease. First of all, we learn that he is a boatman by occupation, a position in life of great hardship and exposure, and of great temptation; but he denies having had syphilis, and there is no history of rheumatism, so that we fail to find a diathetic cause for the brain lesion. Is it a case of cerebral hemorrhage? We reply in the negative, because there are no evidences of chronic arteritis, leading to the formation of miliary aneurisms, the central point in the pathogeny of cerebral hemorrhage. Although in the so-called paralytic form, even the most temporary loss of consciousness may not occur, there are present, besides evidences of degeneration of the vessels, very marked disturbances of the cerebral functions. It is true, in very young subjects cerebral hemorrhage may occur as a result of syphilitic disease of the arterial tunics, and of deposits (gummata) in the perivascular spaces, but, as already remarked, there is no history of syphilis. The symptoms in this case were such as attend obstruction of a cerebral vessel of small size; but not such obstruction as is produced by endarteritis and thrombosis. The form of blocking here is that of an embolus. The closure of the vessel occurred with comparative suddenness, without disturbance in the intellectual sphere, but with complete loss of motility. It is obvious, then, that the damage done was in a motor centre, and, as the right side was the seat of the paralysis, we may conclude that the embolus was lodged in the outermost part of the left *corpus striatum*, or in the white matter adjacent. I assume that the obstruction was sudden and complete, but far from extensive. Rejecting, as I have done, the other causes of obstruction, it is plain that the embolus came from a distant part of the vascular system. I need hardly state that we must look to the heart in explanation of the obstruction. When I come to apply the stethoscope to the cardiac region, my attention is at once arrested by a loud bellows murmur, audible with the greatest intensity in the aortic area, and synchronous with the systole. Having now the usual collocation of symptoms, namely: cardiac disease, right hemiplegia, it may be useful to indicate the reasons for this arrangement, and, further, to attempt to explain why we have not had here *aphasia* as one of the related symptoms. When endocarditis occurs, as everybody knows, so-called vegetations form, due chiefly to alterations in the parenchyma, but consisting also in part of fibrine whipped out of the blood. It is, of course, perfectly easy to comprehend how emboli may be detached, and entering the circulation be deposited in distant vessels. If so, what is the relation between the valvular lesion and the cerebral, as we find them in the case before us? The anatomical arrangement is such as to favor the passage of an embolus into the left hemisphere; the left common carotid is in a line with the blood current from the aortic orifice, and is given off directly from the aorta. The arrangement of the intra-cranial arteries is such as to direct an embolus into the left middle cerebral. It results from these facts that in a majority of cases we have the collocation I have dwelt on, namely: cardiac disease, right hemiplegia, and aphasia. That aphasia did not coexist in the case before us, is due to the deposition of the embolus in a vessel distributed to parts posterior to the seat of the language faculty.

I must now call your attention to the results of an embolic blocking of a cerebral vessel, as illustrated in the case before us. The kind of symptom produced will depend, necessarily, on the seat and extent of the affected part. A closure of a vessel in the medulla oblongata, for example, would produce very different symptoms from a similar accident in the *corpus striatum*. The immediate effect of a blocking of a cerebral vessel is an arrest of function of the part which this vessel supplies with blood. The localized anæmia thus induced at once disturbs the intra-cranial blood-pressure; collateral hyperæmia and œdema ensue, and important nutritive alterations quickly take place. When a motor centre is thus suddenly deprived of blood, it at once ceases to functionate, and the members with which it is anatomically associated are said to be paralyzed. That is the accident which has happened to the patient before us.

Having determined the character of the case with which we have to deal, it remains to indicate the appropriate remedies. The therapeutic nihilism which is now the fashion would influence me, if my convictions were not firmly settled in another direction, to adopt a negative course: to advise rest, quiet, and a suitable diet, and await by a "masterly inactivity" the results of nature's efforts. I believe that much can be done, even in such an unpromising case, by suitably directed therapeutical means. The problem is, How to remove an obstruction in a distant vessel? If my theory is correct, the obstructing material is fibrinous in character, and the only possible means of removing it, and thus clearing the vessel, is to act on it by some suitable solvent. It is in a high degree probable that ammonia has the power to dissolve such an obstruction. At least, I may say, that ammonia has seemed to me to possess this power. Whenever all other reasons fail him the practitioner can quote experience to justify his action. As to the mode of administration, ten grains of the carbonate of ammonia can be given in a tablespoonful of solution of the acetate four times a day. When any reasons exist for supposing that a syphilitic taint is present, iodide of ammonium may be added to the prescription.

As this is a point of practice to which I wish especially to call your attention, I should not fail to mention that I have had results, to me surprising, in the use of this remedy or combination, in cases of cerebral obstruction due to chronic endarteritis, a condition of things so common in the aged. Giving this remedy, and seeing the signs of obstruction removed, I could not fail to connect the two events, the more especially as such improvement does not occur in the same class of cases, when the patients are left to nature.

[*Note.*—Under the use of the remedies above mentioned, there was considerable improvement in the condition of the patient. In the course of several months fresh difficulties arose, due, doubtless, to the very disturbed action of the heart. After death the cardiac lesions amply confirmed the diagnosis; one segment of the semilunar valves was partly torn from its base, and it was covered with vegetations. The embolus could not be found—it would be more accurate to say, could not be sought for—owing to peculiar circumstances, but softening and collateral hyperæmia and œdema were found in the situation diagnosticated.—R. B.]

2. *Epilepsy; Bulimia; The Milk-Cure.*

I have now to present an interesting example, and a most instructive one, of that sad disease—epilepsy. It is not my intention to deliver a didactic discourse on this disease; but to lay before you some important principles which should guide you in the therapeutical management of such cases.

As you can hardly fail to observe, the patient is a young woman in apparently good health. Acne are to be seen on her face, but this eruption is probably due to the use of bromide of potassium. Her countenance has the sad, pitiful expression—the physiognomy of epilepsy—but otherwise there is nothing external to indicate the presence of disease. But we learn from her mother that she has had convulsions for fourteen years. The seizures are characteristic in respect to all the objective phenomena: the cry; the deadly pallor of the face; the tetanic fixation of the muscles of respiration; the cyanosis; the general convulsions; the after-coma. The fits are becoming more frequent, notwithstanding the pustulation of the face indicates the free use of the bromide of potassium; they occur every night, and sometimes three in a night. It does not surprise us, under these circumstances, to learn that her mind is deteriorating. The treatment, pursued by various physicians, has consisted chiefly in the administration of the bromide of potassium. It is needless to say that thus far no advantage has resulted. It is obvious that the effect sought to be obtained was the arrest of the convulsions by the administration of a sufficient quantity of the bromides. It is a highly instructive fact, that altogether the most efficient remedy in the treatment of epilepsy has failed to ameliorate even the condition of our patient. Prescribing for a disease has, you perceive, utterly failed. To continue to perpetrate this error would be simply foolish; we must ascertain, if we can, the underlying morbific influence.

Besides the epilepsy, what evidences exist of disease anywhere in the organism of our patient? As an intimate relation subsists between the sexual system and the cerebral, we at once inquire into the condition of the uterus and ovaries. We find no evidence of disease in these organs; not even functional derangement exists. Examination of the urine discloses a healthy state of the kidneys. The organs of circulation and of respiration perform their functions in a perfectly normal manner. In fact, excluding epilepsy, our patient presents no evidence of disease anywhere except in the organs of digestion. She has an appetite that can hardly be appeased—a canine appetite. Her mother tells me that she exhibits positive greed; that she bolts her food; that she snorts and blows with eagerness and haste; that she is like a carniverous animal, indeed. Swallowing in this way an extraordinary amount of food, we cannot be surprised that she suffers with a strong sense of discomfort after eating. She also regurgitates a part of her meals; acidity and flatulence are always present; the abdomen is distended, hard, and resonant on percussion, and an obstinate constipation, requiring the frequent use of purgatives, is a constant condition. Besides these symptoms, due to indigestion and a catarrhal state of the stomach, she has frequent attacks of gastralgia of a violent kind. We can have no difficulty in coming to a conclusion in regard to the present state of her digestive organs. On further investigation, I find that the first attacks of convulsions were apparently produced by acute indigestion. In fact, the disorders of digestion long antedated the convulsive seizures. We learn that no convulsions occurred during the teething period.

Before considering the question of the relation of the stomach disorder to the convulsive seizure, I must say something in regard to the notions which formerly obtained on the subject of intrinsic and extrinsic causes. It is only lately that a proper distinction has been made between true or essential epilepsy and epileptiform attacks. Formerly, every case of eclampsia, occurring subsequently to puberty, was held to be epilepsy. The convulsions which attend on intra-cranial lesions — for example, a tumour — were classed in the same category. You know, of course, that epilepsy is a neurosis—a functional nervous disorder—and that it has no constant association with any anatomical change. It is true, a great many lesions of the brain, and of its membranes, have been found after death; but such changes do not stand in a necessary causative relation to the convulsive seizures. On the other hand, various lesions in distant parts of the body have excited convulsions, as a tapeworm in the intestines, a stone in the bladder, an injured nerve filament in an extremity, etc. These two classes of causes, exciting an epileptic paroxysm, might be grouped as intrinsic and extrinsic. A moment's consideration will be sufficient to convince you that such a division will include cases of tumour of the brain, abscess of the brain, and other lesions; and will also include epileptiform seizures of a few days' duration, due to a mere irritation of a distant organ, and removable, it may be, by mechanical means.

The only extrinsic cause of eclampsia in our patient, so far as I have been able to discover, is the very pronounced stomach disorder, the details of which I have laid before you. It is probable that this long-standing stomach disease has been aggravated by the enormous doses of bromide of potassium which she has taken. When an attack is imminent, our patient feels a strange sensation in the epigastrium, and an influence which rises to the brain; consciousness is then lost. Is this an aura? It can hardly be so considered. In my experience, an uneasiness at the epigastrium is one of the most common sensations felt by patients at the beginning of the attacks, and occur in the case of those who have a distinct aura proceeding from a distant part of the body. This epigastric sensation is so common because, in a very large proportion of cases, epileptics have inordinate or canine appetites, or they bring on gastric derangement by bolting indigestible food. On strict investigation, we find that gastric troubles preceded the fits in the case before us, so that the former stood in a causative relation to the latter, it is at least highly probable. To have an extrinsic cause produce such a perturbation as a convulsion, there must exist the so-called "neurotic temperament," or an abnormally excitable condition of the "spasm centre."

If the pathogenetic theory, just proposed, is correct, the most important part of the treatment will consist in remedies addressed to the stomach. In fact, we have already learned the inutility of treatment addressed to the disease, merely in the failure of the treatment heretofore pursued. In some cases of a similar kind, which have been in my charge during the past few years, I have learned the extraordinary value of the milk cure. For example, a young lady, who had been relieved of a tapeworm a short time previously, suffered from an extreme degree of gastro-intestinal catarrh. She became very anæmic, and as a result of the anæmia apparently, and after the expulsion of the parasite, she began to have epileptic attacks. The seizures were nocturnal chiefly, and a number occurred every night. She was treated in the most orthodox manner for the anæmia, and she had a great many remedies for epilepsy; but neither the anæmia, nor the epilepsy, were in the least degree improved. The fact is, a large part of the food with which she was stuffed was not digested, and did not benefit her in the least. I conceived the idea of treating her with milk to give the digestive organs an opportunity to recover. The result was most surprising; she did not have a fit after the treatment was fairly begun, after the first day. The digestive organs quickly improved in condition, so that she was able to bear the bromides in a few weeks. I do not doubt that I will report an equally favourable result in the case before us. She will be placed on the exclusive milk-diet as you have heard me describe it, and, as improvement in the condition of the digestive organs occurs, her dietary will be enlarged carefully until, finally, she will have a diet exactly suited to her condition. To hasten the restoration of the diseased mucous membrane, I will direct her to take a drop of Fowler's solution of arsenic three times a day.

When the stomach is relieved, we will find that the convulsive seizures will, at least, be greatly diminished in number. When her stomach is so far restored as to permit the use of solid food, we will then begin the administration of the bromide of potassium. In a few weeks the patient will be shown to you again, when you will be able to judge for yourselves how far success or failure has attended our efforts.

[The patient was presented to the class at the expiration of a month, when the professor made the following remarks:—]

The patient before you will be remembered as the girl with nocturnal epilepsy, three or more attacks occurring at night. Under the treatment then instituted, there was an immediate decline in the number of attacks, and for two weeks there have been none. The result has thus far justified my opinions and the practice based on them. Sufficient time has not yet elapsed for final conclusions, of course, but the amount of relief thus far afforded our patient justifies much hope for the future. This and other cases in various stages of the treatment will be shown you, from time to time, and then judgments may be formed from competent data.

3. *Cases of Chorea illustrating the Value of Narcotics.*

You are, doubtless, aware of the fact that chorea is one of the maladies which is supposed to demonstrate, in its behaviour under the influence of favourable hygienic conditions, the superiority of nature's methods. It has been shown, you know, that rest, quiet, and good food are quite adequate to effect a recovery in a week or two. Now, the cases I have brought before you to-day, will, I think, prove that there are some cases not so easily disposed of—that Dr. Diet, Dr. Quiet, and Dr. Merryman are not always the invincible practitioners supposed to be by their fast friends, the nihilists. Let me invite your especial attention to the points in the history of these patients which bear on the question of treatment. Both have had distinct choreic movements for a long time—the first and older child, two years; the other, one year. They have been under an entirely judicious management in this house; both have been subjected to the most favourable hygienic influences; but although both improved somewhat, neither has recovered; and at the present time, after an entire suspension of the treatment for several months, they are as bad as ever. I need not tell you that they are fully developed examples of that affection Observe them; the voluntary muscles are in a state of incessant activity, especially of the older girl, and the movements are of the wild, disorderly, and incoordinate kind, so characteristic of chorea. But it was not my intention to deliver a lecture on the symptomatology of the disease.

I have said that the treatment of these girls was, on the whole, judicious; it was certainly orthodox. They had a generous diet; they were given abundantly of iron; they had, also, arsenic, strychnia, and other various, so-called nervines; and although these were patiently tried, recovery did not ensue, and the improvement which certainly did follow the practice was not maintained, for they are here again. It may seem to you extraordinary, that so simple a disease as chorea is not cured. Everybody will admit that there are cases of great severity that may not be cured—that may die even; but, surely, ordinary cases ought to be cured speedily, if our eminent colleagues, the nihilists, permit them to get well on diet and quiet. Any practical physician of large experience with chorea will tell you, if he is honest, that apparently simple, uncomplicated cases sometimes manifest a disagreeable tendency to persist in a modified form, and to linger, month after month, and with varying fortunes, now improving, now getting worse. Examples of this type are before us, and the question is, how shall we cure them? I now promise to redeem our credit in these cases, and bring about a cure. I purpose to treat them by a method which I have found very successful, and for the hint concerning which I am indebted to Trousseau. The method consists in a combination of the hygienical, the tonic, and the narcotic.

To the older girl I will give arsenic, as before—that is, three drops three times a day, after meals; to the other, who has, you perceive, enlarged and suppurating lymphatic glands, I will have administered the syrup of the iodides of iron and manganese. To both, as a part of the curative means, I will give every night, a combination of chloral and morphia—to the elder, ten grains of chloral and a half grain of morphia; to the younger, half of these quantities. I direct the administration at night of these narcotics, not so much to procure sleep as to permit them to sleep off the effects of the remedies, so they may not interfere with the needed exercise in the open air. I predict that good effects will follow this treatment in a few days, and that all choreic symptoms will permanently disappear in a few weeks.

[The girls were presented to the class each week, to note the progress of the treatment.]

It is evident, gentlemen, that my prediction, made several weeks ago, has been fulfilled; no trace of the choreic movements is to be discerned in the voluntary acts, as we observe them to-day. Both patients have improved in condition, and all of the bodily functions are now performed in a perfectly normal manner. I am not unmindful of the good accomplished by hygienic means, nor do I underrate the value of the tonics given; but, as you are aware, I have a strong conviction that the tonics are less influential in effecting such results than the narcotics. With respect to the use of the morphia and chloral, it should be understood that these remedies are employed not so much to procure rest as to exert an antagonistic action against those irregular discharges of nervous force in which the disease consists. The great French clinician gave opium in enormous doses, in the severe cases, to prevent exhaustion from loss of sleep. The amount of morphia which he caused to be administered is almost incredible. To a girl, twenty years of age, he gave thirty grains of morphia a day, for three days; and to another woman he gave fifteen grains at a single dose. Trousseau remarks, in connection with this subject, that medical men dread too much the use of opium in large doses in the neuroses. He stated a fact which I have repeatedly observed myself, that an extraordinary tolerance to its action exists in these cases. In the patients before us this tolerance was exhibited, but not in the heroical fashion, chronicled by the great French clinician. The dose given the older girl was soon doubled; that is, she took one grain of morphia every night until the jactitations ceased, when it was gradually reduced and discontinued entirely with the disappearance of the symptoms.

Finally, I should not fail to call your attention to a little point of practice in connection with the suppurating glands of the neck of the younger girl. You will, probably, remember that I prescribed for her the syrup of the iodides of iron and manganese. I had the abscesses emptied with the hypodermic syringe, and the collapsed sacs injected with the tincture of iodine, undiluted. When treated in this way these abscesses get well in a comparatively short time. Treated in the ordinary way, the pus-sacs allowed the empty themselves, they are extremely slow to heal, and unsightly cicatrices remain to torment the unfortunate patient.

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Summer Prurigo; Prurigo Æstivalis, seu Prurigo Adolescentium, seu Acne-Prurigo. By Jonathan Hutchinson, F.R.C.S., Senior Surgeon to the London Hospital and to the Hospital for the Diseases of the Skin, etc.

Gentlemen: I have had much difficulty in finding a name which should be even tolerably appropriate to the disease which we are about to consider. I am not aware that it has been named or descried by authors. Its prominent features consist in its tendency to relapse, or to continue with but slight intermissions over many years and in spite of treatment, to affect by preference the face and the upper extremities, to be worse in summer weather, and to commence usually at or about the age of puberty. It is generally more or less pruriginous, but not by any means intensely so, and the eruption consists of small red papules which look as if they were about to form pustules, but which never do so (abortive pustules). Unless they are scratched no ulceration takes place and no crusts form. Although, however, there are no crusts, yet minute scars are constantly produced. On the cheeks there is usually a good deal of diffuse erythema, much more than is shown in the portrait which I now exhibit.

In the boy who was the subject of this portrait[1] the disease affected the trunk as well as the upper limbs and face, but in most cases the eruption is limited to the face, neck, and upper extremities. The disease differs in some marked features from that known as "Hebra's Prurigo." First, the pruriginous element is very much less marked and the erythematous much more; secondly, the face is always affected, and the lower extremities less so than other parts; and lastly, whilst Hebra describes his form of prurigo as being always worse in winter, the reverse is the fact in this malady.

It would appear to have some alliance with acne, and on the face might easily be mistaken for that disease, but none of the spots ever pass into acne pustules, nor does it restrict itself, on the *trunk,* to the acne positions. Probably it has supplied part of the material from which the descriptions of *strophulus prurignosus* were given by the old writers; and the *lichen urticatus* of Bateman may possibly have included some examples of this malady in its earliest stage.

The portrait which we have before us is that of a boy named Charles P., and was taken in August, 1867, when he was under my care in this hospital. At the conclusion of our lecture I shall produce the lad and show you that his skin disease has at length quite disappeared. He is now under my care for another malady. The portrait was taken when he was thirteen years of age. He had been the subject of an eruption almost from infancy. It was believed to have begun at six months old. For a long time it always got well in winter and relapsed in summer. He was covered from head to foot with the spots, all his extremities being affected, the palms of the hands and soles of the feet alone being exempt The spots were everywhere scattered, not arranged in patches. They presented conical elevations of a light red tint, and in the centre of some of them were minute accumulations of fluid. Most of them might be described as abortive pustules, for they looked in the early stage as if threatening to become definitively pustular, whilst but few really did so. The skin when he first came to me was marked all over with very shallow white cicatrices which the eruption had left. He had never had smallpox. The eruption showed but little preference as regards different regions. It was, however, especially copious on the cheeks, forehead, and back of neck. He was thin, and his skin was somewhat harsh and brown, but he considered himself in good health. The eruption did not seem to occasion him any great annoyance; he said that it itched only at night, and gave him no trouble in the daytime. He asserted that usually it got quite well in the winter, only coming out in warm weather; but on the present occasion his attack had begun at Christmas, and had persisted during four months of cold weather. He did not notice any difference in his general health.

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[1] See Plate xxxviii. of the New Sydenham Society's Atlas.

The following note records the state of the lad several years later:—

"He has grown well and appears to be in good health. The eruption is at present out only on the backs of his arms, slightly on the forehead and over the buttocks. His skin is everywhere spotted with small cicatrices, most of them very superficial, but so abundant that on his chest, back, and arms a marbled appearance is produced. His mother, who comes with him, states that the first outbreak in infancy occurred after measles, and was supposed to be a 'measles rash.' She says also that it has at times covered the whole surface of the body with the exception of the flexures of the joints and the palms and soles. He has always had it less on the legs than elsewhere, and the parts most severely affected have been the face, backs of the hands, and arms. He has had repeated bad attacks since the portrait was taken, although on the whole the disease appears to be getting milder. For two months at midsummer of this year the eruption was very freely out, and his legs were so much swollen that he was obliged to stay at home. As a rule, he continues regularly at his work, and suffers but little inconvenience from his eruption. He complains somewhat of irritation when he is hot, and he habitually scratches, but he states that he is never kept awake at night by itching."

You will see from this that this case differs somewhat from the statements which I have made as regards the general facts as to this malady. It began very much earlier than is usual, and it has affected a greater extent of surface. The parts which were exempt are almost precisely the same as those which escape in "Hebra's prurigo," with the difference that in the present case the face and the back of the neck are severely affected. We must note also that whilst in the disease described by Hebra the skin becomes dense, hard, and thickened, and there is often a marked tendency to eczema, these phenomena are wholly wanting in this patient.

In further proof that the case does not fit with the Vienna malady, I now produce the patient. Hebra asserts in the most explicit language that the prurigo which he describes is absolutely incurable. This young man, however, although now only twenty-three, has got quite rid of his complaint. It had been slowly declining for some years, and at present his skin is quite free. It is, however, spotted all over with minute white scars, not so deep as those of smallpox, but producing a very curious appearance. He is now under care for strumous disease of both testicles. So much had his appearance altered by the cure of the eruption that I did not in the least recognize him until he reminded me of his identity.

The next case which I shall bring before you is one which in some respects approaches nearer to Hebra's type. In it we have a tendency to eczema, and the patient is as yet far from cured. Here again, however, we must note that it is a summer malady, and further, that it did not begin in infancy. The patient had a clear skin until she was eight years old. Her first menstruation had occurred before any spots showed themselves. Thus it would appear to connect itself with the adolescent period.

Case of very Severe Prurigo, which began at the age of eight, and has now persisted with increasing severity for five years; Summer Exacerbations; Tendency to Eczema; Face affected; Œdema of Lower Extremities.—Harriet S., aged thirteen. In this instance the history, which is given with great intelligence and clearness, is that the child had a perfectly clear skin till the age of about eight years and a half, that she was not liable to irritation from fleas, that she had had chicken-pox at five, and had had nothing unusual after it. When she was eight years and six months old she menstruated for the first time, and very shortly afterwards began to suffer from an eruption on her arms. At this time she was accustomed to have the arms bare. The weather was hot, and the first suspicion was that the eruption might have something to do with the heat. From the first it itched very much, so that the child's mother used to tie up her hands to prevent scratching. She got better in winter, but it did not quite leave her. It relapsed again the next summer, but continued for two years or more quite confined to the arms. Next it extended to the shoulders and trunk, and then passed over the body. It is only for the last three or four years that it has affected the face.

At the present time (October 30, 1875) she is very much better, partly in connection, probably, with the time of the year, and partly from treatment with the tar baths. During the past summer she was for two months in the London Hospital (under a colleague); the eruption was very bad, worse than ever before, when she went there; it had been getting worse every summer.

The eruption avoids the parts where the skin is thin. Thus, the flexures, the sides of the neck, and the adjacent parts of the chest are free. It is very severe on the shoulders, backs of the upper extremities, the whole of the back, on the hips, and on the whole of the lower extremities excepting the popliteal spaces. On the face it is severe on the sides of the cheeks and below the ears, whilst it extends with slighter severity over the whole of the front of the face and forehead. It was formerly present severely on the backs of the hands, but is now nearly well there. It extends also on to the whole of the dorsal surfaces of the feet. It does not affect with any special severity either the fronts of the knees or tips of the elbows, though a few spots are seen there. The palms, soles, and scalp have always been quite free. The eruption is modified at such an early stage by scratching that it is difficult to say with confidence what its original type may have been. It consists at present of small papules with ill-defined borders, which are either simply abraded or covered by a thin adherent scab. Amongst these papules are everywhere numerous white superficial scars. The skin is discoloured and harsh, and at some parts decidedly thickened. On the lower extremities there is decided thickening of the subcutaneous cellular tissue, so that a line is seen where the tops of the boots press, above which the whole leg is equally swollen.

The spots have always been liable to bleed when scratched. No evidence of pediculi now, but at one time she had some on the head, but without relation to the disease. There is no history of skin diseases in the family, and she is the only one out of seven children who has any eruption.

The child has been under much medical treatment, and three years ago was an out-patient for a long time at one of our largest hospitals. She has already derived great benefit from the use of a tar bath every night, and now sleeps fairly.

Her mother considers that the condition described in the above notes is the best that she has attained in the summer for several years past. Although much better in the winter, she has never got quite well.

This case bears in most respects a very close resemblance to that of the lad Charles P. It differs from that case chiefly in that the pruritus has been far more severe. In P., although the irritation was worse at night, he was never kept awake, and in the daytime he had no itching whatever. In P. the disease had begun in infancy, whilst in this girl it did not occur until the age of eight. In both cases the entire exemption of the palms, soles, and scalp, and the comparative freedom of the flexures and other parts where the skin is thinnest, are to be especially observed. Again, in both cases we have the strong statement that the disease is worst in summer and comparatively if not absolutely well in cold weather. In both the skin of the back is marbled over by superficial white scars. In both there has been a tendency to inflammatory œdema of the lower extremities when the eruption has been severely out. In Charles P.'s case it was suggested that the disease was consequent on measles, but in the case of the girl there is no such hypothesis, and the evidence is clear that it began on, and was for a considerable time restricted to, the upper extremities, and that it only spread after a considerable period to the rest of the surface. We may note that this latter fact is tolerably conclusive as to the disease not having begun from the irritation of lice, for it attacked the arms first—the parts which would almost certainly have been avoided by these parasites. The evidence in the girl's case is yet stronger than in that of the boy in favour of the supposition that the disease is a pure prurigo, and that the papules, pustules, scabs, and other evidences of inflammation of the skin, are secondary, and due almost wholly to the patient's scratching. In neither case has there been at any stage any tendency to the formation of wheals, as in urticaria. The degree of chronic thickening of the skin appears to be in proportion to the scratching, and is much more marked in the girl's case than in that of the boy.—*Med. Times and Gaz.*, Feb. 16, 1878.

(*To be concluded.*)

HOSPITAL NOTES AND GLEANINGS.

Uterine Hæmatocele.—The following case was treated by Dr. Hall Davis at the Middlesex Hospital, and, according to the editor of the *Lancet* (March 30, 1878), it is "inferentially conclusive against female accoucheurs."

P. W——, the subject of this case, was a young and single woman, aged twenty-one, a brunette of medium stature, fairly nourished, a waitress, and a native of Folkestone. She was admitted Nov. 22d, 1877, and discharged convalescent Dec. 22d.

The previous history of her family was unimportant; that of herself was as follows: Menstruation commenced at the age of seventeen years, but up to April, 1877, her "periods" were irregular, sometimes absent for three or four months, but from April up to the time of the present attack menstruation had been normal. While menstruating, seven days before admission, she was suddenly seized with severe abdominal pain and prostration, and later with vomiting, diarrhœa following shortly after. She soon noticed for the first time a hard swelling in the hypogastrium, very tender on the least pressure.

On Nov. 18th, Dr. Hall Davis was requested by her mistress to see her. Diarrhœa had then ceased, but the vomiting and severe abdominal pain continued. The pulse was small, 130; temperature 102°; face blanched; expression anxious. A solid enlargement, well defined, having a pretty uniform surface, was felt extending from the pelvic cavity up to the navel, and to an equal extent on each side of the linea alba—namely, opposite to the middle of each Poupart's ligament. Vaginal examination presented conditions hereinafter described. The cause of the attack appeared to have been exposure to cold and over-exertion during the menstrual period. Suppositories of morphia, one-third of a grain, were administered as often as required, linseed poultices were applied to the abdomen, and ice was given to suck. Upon this the pain and vomiting subsided, and on the fourth day she was, for better nursing, removed to this hospital.

On admission the pulse was 108, the temperature 98.8°, and the respiration 36. The urine was free from albumen. The tongue was white-furred, the papillæ prominent. There was an abdominal enlargement as above described—now, however, bearing firm pressure; it yielded no pulsation, murmur, or fluctuation, and was dull on percussion. Vaginal examination detected a small cervix, an enlarged body of uterus, a solid deposit behind the body of uterus and to left of it, and tender on pressure. On Nov. 23d the pulse was 120 and the temperature 100.8°. Recurrence of vomiting and pain required a return to the morphia suppositories, of which three were administered before bedtime. Ice and hydrocyanic acid were given every four hours, with soda-water. She was nourished by enemata of beef-tea, egg, and a little brandy. She passed a good night, and on the following morning the vomiting had ceased and the pain was slight. On the 27th the pulse was 96 and temperature 98°. No pain unless when moved. The mass felt per vaginam contiguous to the uterus was softer and less tender; the abdomen also was less tender. From this time there was a steady improvement: although the abdominal tumour had not decreased in size by Dec. 2d, it was softer. On the 6th the tumour was less, the os uteri was soft and patulous, and a glairy, sanguineous discharge, evidently menstrual, escaped from the uterus. Two days later the abdominal tumour was still softer, its upper boundary being three-quarters of an inch below the umbilicus. On the 11th the uterine tumour did not extend higher than an inch and three-eighths below the umbilicus, and its breadth was three inches. By the 18th the tumour had sunk its upper limit to two inches and a quarter below the umbilicus, and the breadth was two inches and six-eighths. She left the hospital, convalescent, for Folkestone.

In February she presented herself for inquiry, when the uterus was found to have become entirely a pelvic organ, and but little larger than normal. She had again menstruated.

Remarks.—The diagnosis and cause of the malady were evident from the history, viz., a rapid enlargement of the uterus, and solid deposit in some of its connections, occurring in the course of a menstrual period from over-exertion and exposure to cold, an effusion of blood into the cellular tissue of the parts affected being the consequence, accompanied by temporary prostration. The treatment was adapted to the symptoms, the vomiting and the severe pain, due partly no doubt to local pressure by the effused blood, partly also to local peritonitis. The absorption of the effused blood was sought to be promoted by the exhibition of iodide and bromide of potassium, and the application externally of iodine ointments. Complete rest in bed for the requisite period, and removal to the seaside on leaving the hospital, were not unimportant elements in the cure.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

The other Cinchona Bases compared with Quinia.—Dr. William K. Newton, of New York, in a short article on this subject (*Med. Record*, April 6, 1878), deduces from given data that the cinchona bases compare with quinia as follows, in the order given:—

Quinidia sulphate, when chemically pure, is almost a duplicate of quinia, and may be given in the same doses; it does not cause any more gastric troubles than quinia; even the commercial salt is as efficacious as quinia.

Cinchonidia sulphate is also closely allied to quinia in its effects, and may be given in the same doses; but it is more apt to cause nausea and vomiting, and even purging, than quinia or quinidia. This salt is not recommended in diseases of the genito-urinary system, or after operations on this tract; neither is it to be given when shock exists.

Cinchonia sulphate is a valuable antiperiodic, but must be given in larger dose than the other salts. It is quite apt to produce gastric disturbances and cause purging.

Thus it may be seen that the three alkaloids may be substituted for quinia; but that quinidia and cinchonidia are better substitutes for that salt.

Death from Chloroform.—A lady, aged thirty-four, died at Philadelphia, on the 20th of March, from the inhalation of chloroform, administered prior to the extraction of some teeth. *Post-mortem* examination revealed a fatty heart.

Kentucky State Medical Society.—This society met at Frankfort on the 2d of April. Owing to the decease of Dr. L. P. Landell, Sen., President elect, Dr. Dismukes, senior Vice-president, presided.

The following officers were elected for the ensuing year: President, Dr. Charles A. Todd, of Owensboro'; Vice-Presidents, Drs. W. H. Wathea, of Louisville, and A. Price, of Harrodsburg; Secretary, Dr. J. Letcher, of Henderson.

Iowa State Medical Society.—The twenty-sixth annual session of the Iowa State Medical Society was held in Des Moines, January 30–31, 1878. There was a large attendance and an interesting session. The following officers were elected for the ensuing year:—

President, A. M. Carpenter, M.D., of Keokuk; Vice Presidents, D. W. Crouse, M.D., of Waterloo; G. W. Carter, M.D., of Marshalltown; Secretary, J. F. Kennedy, M.D., of Des Moines; Treasurer, Dr. G. R. Skinner, of Cedar Rapids.

The next session will be held at Davenport, the last Wednesday of May, 1879.

Medical Graduates in 1878.—(Continued from page 59.)

Atlanta Medical College	24
Columbus (O.) Medical College	50
University of Louisiana	56
University of Nashville and Vanderbilt University	90
Rush Medical College (Chicago)	129
Chicago Medical College	47
Detroit Medical College	20
McGill University (Montreal)	27

Obituary Record —Died, in Philadelphia, April 6th, 1878, **Francis Gurney Smith, Jr.**, M.D., in the 61st year of his age.

We regret to announce the death of this well-known physician and teacher of medicine. He began his public life as a lecturer on Physiology in the Philadelphia Association for Medical Instruction, and subsequently held the corresponding chair, first in the Pennsylvania Medical College, and afterwards for fifteen years in the University of Pennsylvania. At different times he was a Resident Physician in the Insane Department of the Pennsylvania Hospital, and Attending Physician to St. Joseph's, the Episcopal, and Pennsylvania Hospitals, and to the Orphans' Asylum of this city. During the civil war he was Surgeon in charge of the U. S. Army Hospital, Christian St., and was afterwards Government Physician to the U. S. army officers in Philadelphia. He was Chairman of the Committee of Publication of the American Medical Association from 1856 to 1876, and editor of the *Medical Examiner* from 1849 to 1853. He was the American editor of Marshall's *Outlines of Physiology*, of Carpenter's *Human Physiology*, and of the same author's work on the *Microscope.* He also translated an abstract of Barth & Roger's *Manual of Auscultation;* and, along with Dr. John Neill, prepared the *Compendium of Medicine*, which was long a favorite text book with students. Dr. Smith was a Vice-President of the American Medical Association in 1870; Fellow of the College of Physicians, and a member of several medical societies; of the Obstetrical Society he was one of the original members, and its first President, serving from 1868 to 1872.

This enumeration of the offices held and the works published by Dr. Smith suffices to prove that he was an industrious man, for none other could have fulfilled as he did the duties they imposed. He took especial interest in didactic and clinical teaching. Beginning his professional career as a teacher, he speedily gathered around him as office pupils a number of devoted young men, many of whom became students of the Association for Medical Instruction. In that self-created Faculty he found colleagues as enthusiastic and ambitious as himself, nearly all of whom subsequently became professors in medical schools. There he learned the art of lecturing, and with great pains sought to perfect himself by collecting ample materials, arranging them logically, and illustrating them abundantly, thus convincing the judgment of his hearers as much as he secured their attention by his earnest and winning style of delivery. Probably no medical professor devoted more time to the preparation of his lectures, even in their minute details, and hence they always left upon the minds of his class an impression of completeness that few others produced. He was one of the first in this country to illustrate physiology by means of living animals, and to use for class demonstration of microscopic objects the electric light, the camera, and the screen. His experiments were so carefully prepared that they rarely failed of their purpose, and were received enthusiastically by his delighted audience. In his hospital lectures he strove to inculcate physiological views of diseases and their treatment, a method which is fitted to impress the memory and gratify the craving for rational explanation. When increasing business and failing strength compelled him to divest himself of a portion of his public duties, there was perhaps none that he gave up so unwillingly as his clinical lectureship. The practice of Medicine and Obstetrics was, however, his first love and his last. The stern but salutary law of necessity compelled him to hew a road to reputation and independence; and, in order to achieve this purpose, he relinquished almost every pleasure to which his social position, his education, love of general knowledge, and refined taste invited him. His excessive devotion to professional duty beyond all doubt laid the foundation of the diseases which aged him prematurely, and ended his life when he had earned the right to enjoy it. His career as a practitioner was singularly fortunate in that from the first his admirable principles and breeding secured for him the confidence of the refined and influential classes, whose friendship he retained to the end of his life. He was never content with a mere discharge of duty, but always, in the liberality of his attentions and his personal interest in his patients, gave far more than mere duty required, and than any pecuniary return could compensate.

Dr. Smith took a lively interest in the University, his Alma Mater in letters as well as Medicine, and especially in the changes attending its removal to West Philadelphia. We believe that no one else procured by personal influence such large contributions to the building fund of its medical department. When at last ill health compelled him to resign his chair, no better proof could be given of his having filled it with unexceptional ability than the difficulty felt by the Board of Trustees in finding a competent successor; for, although more than a year has elapsed since his resignation, no permanent appointment to the place has yet been made.

Dr. Smith had a manly, erect, and graceful figure; a bright and prepossessing countenance; a singularly sweet and gentle voice; and his manners were both courteous and dignified. Witty and humorous, his social companions were often made merry by his sallies and anecdotes, and his equitable judgment influenced their opinions. His candor and sincerity were above all suspicion, and he lived, as he talked, in perfect harmony with himself and truth. He has left behind him a character which, for symmetry, solidity, and purity, has seldom been equalled, and which may serve as a model to all who feel that the highest professional station is most illustrious when it is adorned by the most sterling moral qualities.

FOREIGN INTELLIGENCE.

The Physiology of Voice and the Phonograph.—The years 1877 and 1878 will be noted in the annals of science for the great additions which have been made to our knowledge of acoustics, and especially to the physiology of speech. Hitherto all attempts to construct a musical instrument capable of imitating the human voice have been so far failures that the idea was very generally held that the sounds peculiar to the voice of man were producible only by means of the human larynx and the human mouth. Edison's phonograph, however, has revolutionized our ideas on that point, for in it we are confronted with the phenomenon of a machine, made entirely of metal and paper, emitting articulate words in tone and measure resembling those of the original speaker. The human quality of the words emitted by Edison's phonograph is calculated to astonish and appall those who hear it for the first time, and the extreme simplicity of the mechanism adds greatly to our wonder at the result. The phonograph is formed of a receiving drum, a recording cylinder, and a transmitting drum. The receiving drum consists of a disk of thin metal fitted into the thin end of a short conical tube. This disk has a blunt needle fastened to its centre, and this needle can be made (with each vibration of the disk) to impinge on the recording cylinder. The necessary vibrations of the receiving drum are caused by speaking loudly and distinctly down the conical tube of which it forms the end. The recording cylinder is made of brass, and is about four inches in diameter. It has a revolving and a horizontal motion, and is marked on the surface by a spiral groove, the thread of which passes exactly opposite the needle of the receiving drum. When it is desired to make a record of a sound or a speech the recording cylinder is covered with a thin sheet of tinfoil, which is readily indented by the slightest movement of the needle of the disk of the receiving drum which impinges upon it, each dent in the tinfoil sinking into the groove of the cylinder. The cylinder is set in motion, and at the same time some one speaks loudly and distinctly into the tube of the receiving drum, thereby causing the drum to vibrate in response to each wave of sound. As a result of this we see the surface of the tinfoil marked with a spiral line of tiny indentations, which have been made by the needle of the receiving drum, the characters of the indentations varying remarkably with the pitch and characters of the sound which had produced them. Thus the record is made by the production of inequalities on the surface of a sheet of tinfoil by means of a needle attached to a vibrating disk. These inequalities are capable of causing in the transmitting drum vibrations exactly similar to those to which they owe their origin. The transmitter consists of a paper drum-head fixed in a circular frame. In front of this drum-head and attached to its frame is a steel spring, the end of which, just opposite the centre of the drum-head, is furnished on one side with a needle, which can be made to impinge on the spiral groove of the cylinder, while from the other side a silk thread attaches it to the centre of the drum-head, the thread being sufficiently taut to keep the drum-head slightly convex. The cylinder being brought back to zero, and the needle of the transmitter being made accurately to impinge upon it, we hear, when the cylinder is made to rotate, the sound produced by the vibrations of the drum-head as the inequalities of the tinfoil travel over the end of its spring needle. This sound is almost indistinguishable from the human voice.

By means of a water-tympanum the horizontal vibrations of the drum-head can be made to move a pen vertically, and we are thus enabled to get a tracing, showing the force and duration of each vibration. Such an arrangement is called a phonautograph. The phonograph and the phonautograph present us, as it were, with the ground plan and section of the waves which produce articulate speech.

The complicated mechanism with which we speak, a mechanism the perfection of which is ever a source of wonder, is not, it must be remembered, a simple acoustic instrument. Its various parts have more than one function, and these functions, so intimately connected with nutrition and respiration, are each of them more essential for the life of the individual than speech. As regards speech itself, it is wonderful how little seems to be absolutely necessary for its complete performance. The utterances of ventriloquists have made it highly probable that very perfect articulation is producible without any appreciable movement of the lips or tongue, and experiments made for us by disease and surgery have confirmed these surmises. Operations for removal of the tongue have proved that a man can talk fairly well without this organ; loss of the epiglottis causes only a slight alteration of the character of the voice; one vocal cord (in cases where one is completely ulcerated away) seems capable of producing sufficient vibration for the purposes of phonation, and where both are removed the aryepiglottic folds, as Dr. Yeo and Mr. Lister have lately shown, seem capable of, in some sort, supplying their place; or, as Dr. Foulis has demonstrated, the function of phonation can be performed by an artificial reed placed in the larynx, the sound of which is capable of being moulded into articulate speech by the cavities of the mouth and nose. Lastly, the phonograph shows us that the majority at least of articulate sounds are producible without the aid of the peculiar resounding cavities of the mouth and nose; and some experiments conducted by Fleeming Jenkin and Ewing, which are foreshadowed in last week's *Nature* seem to indicate that Helmholtz's theory, that the vowel sounds are due to the prominence of notes of absolutely definite pitch, is not tenable. The pitch of the sounds emitted by the phonograph varies with the rate of its rotation, and Messrs. Jenkin and Ewing have found that the character of the vowel sounds is accurately maintained, no matter how quickly the cylinder of the instrument be made to revolve.—*Lancet*, March 23, 1878.

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Pulmonary Hydatids in a Child.—Dr. Toeplitz, of Breslau, relates the case (*Berlin. Klin. Wochenschr.*, No. 24, 1877) of a boy, five years of age, who at Christmas, 1875, was attacked with febrile symptoms and cough, without any appreciable cause. The cough persisted, short and dry, and resisted ordinary remedies. At the beginning of March, 1876, when apparently quite well, the child was seized with a severe paroxysm of coughing and symptoms of imminent suffocation, the attack terminating with the expectoration of a dense, yellowish-white membrane, covered by blood-stained mucus, and followed by slight hæmoptysis. Other attacks ensued at intervals, and after the fourth of these the child was brought to the hospital. It was well developed; pulse 144; temperature normal; respiration 40, not laboured. Thorax was well formed, but there was appreciable bulging of the right side, especially at its lower part; and there was dulness on percussion over the right back from the spine of the scapula downwards, and in the axilla. Anteriorly, the resonance became impaired from the fifth rib downwards. The breath-sounds and vocal fremitus were much weakened over the dull area. The apex of the heart impinged slightly outside the left nipple. The expectorated membrane was structureless and hyaline in appearance, but at its margin the characteristic lamination could be detected. No hooklets were found. On two subsequent occasions, in the month of May, more membrane was expectorated, and hæmoptysis was occasionally produced. The treatment was mainly medicinal, iodide of potassium being freely given. By September the cough and other symptoms had disappeared, but the physical signs remained unchanged. It appears that the child was in the habit of playing with a dog belonging to its parents, and it is quite possible that it may have become infested with the echinococcus through this animal.—*Lancet*, March 16, 1878.

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The Rôle of Lymph in the Cicatrization of Wounds.—In a paper read before the Société Médicale du Haut Rhin, Professor Koeberlé discussed the part played by lymph in the cicatrization of wounds. He remarked that as long as the flow of blood continued that of the lymph was unobserved. Yet it is well known that in a cut which affects lymphatics as well as bloodvessels, lymph continues to flow in spite of the exercise of an amount of compression sufficient to arrest hemorrhage. This exudation is only stopped when the occlusion of the lymphatics is complete. After a certain time this liquid, at first very fluid, becomes plastic; it contains fibrine which undergoes coagulation, as may at any time be seen on wounds caused by vesicatories. On this account, therefore, lesions or cuts intersecting the lymphatics are more difficult than others to heal by the first intention. Moreover, the lymph easily becoming puriform gives rise to the sanies which, infiltrating the tissues, occasions erysipelas, secondary hemorrhages, and other accidents consecutive upon a wound. This stagnation of the sanies is rendered evident by redness and pain occurring at some point in the line of the cicatrix. It then becomes necessary to allow of its escape by opening the wound at this point. Observation shows that in the middle line of the body, where there are few lymphatics, immediate union often occurs; and further, that longitudinal incisions, which do less injury to the lymphatics, heal better than horizontal ones. Professor Koeberlé hence draws the conclusion that, when practicable, incisions should be made parallel to, and not across, lymphatic vessels.—*Lancet*, March 16, 1878.

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The Composition of Pus.—The twenty-fifth part of Fehling's *Neue Handwörterbuch der Chemie* contains a short but carefully worked-up article on pus, in which, after some preliminary account of its general characters, the following particulars are given. The constant chemical constituents of pus are water, alkali, albuminate, and three other albuminous bodies, one of which coagulates at 48° to 49° C., and is insoluble in a 0.1 per cent. solution of common salt and in a dilute solution of soda; a second insoluble in water, but swelling up in a solution of salt, and soluble in a 0.1 per cent. solution of hydrochloric acid; and a third insoluble in a solution of salt, but soluble in a 0.1 per cent. solution of hydrochloric acid. In addition it contains nuclein, fats, soaps, cholesterin, lecithin, cerebrin, phosphuretted fats, and inorganic salts, of which the chief are sodium chloride, phosphates and carbonates of the alkalies, phosphate of lime, and some iron oxide. The nuclein albuminous constituents, cerebrin, cholesterin, and lecithin, belonging to the pus-corpuscles. The occasional or, as they may be regarded, abnormal constituents of pus are mucin (from mucus membrane), chondrin, gluten, chlorrhodinic acid, pyocyanin and pyoxanthosis (in blue pus), biliary acids and pigments (in the pus produced in icteric patients), grape sugar (in diabetics), and urea. When long exposed to the air, pus passes into acid fermentation, and then contains leucin, formic, butyric, and valerianic acids. Hoppe Seyler found in 100 parts of the serum of pus: water, 90.96 per cent.; solids, 9.04, of which albuminoids formed 7.02; lecithin, 0.10; fats, 0.04; cholesterin, 0.07; alcohol extract, 0.06; water extract, 0.92; inorganic salts, 0.77. One hundred parts of dry pus-cells contained albuminoids, 13.726; nuclein, 34.257; insoluble substances, 20.566; fats, 14.383; cholesterin, 7.400; cerebrin, 5.199; extractive, 4.433; and nearly 2 per cent. of salts.—*Lancet*, March 16, 1878.

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Deafness in Bright's Disease.—In a paper in the *Gaz. Heb.*, Jan. 23, Dr. DIEULAFOY calls attention to the fact that deafness in various degrees is a much more frequent phenomenon in Bright's disease than the few allusions made to it by writers on this affection would lead us to suppose. Since he has paid attention to the subject, he has found various affections of the ear prevail (from complete deafness to mere impairment of the sense of hearing or noises in the ear) in fifteen out of thirty-seven cases of chronic or acute nephritis that have come under his notice. As to the forms of Bright's disease to which these troubles of audition chiefly belong, before this can be determined many more cases with autopsies will have to be observed; but, at all events, no form of the disease is exempt from such accompaniment, which may occur at any stage of the disease, although, while sometimes preceding other symptoms, it most frequently does so at an advanced period of it. Generally these disturbances of audition are temporary, lasting for days or weeks, when they may diminish or disappear, to reappear at a future time. In only one of the cases observed did the deafness become permanent. These disturbances of hearing may sometimes prove useful in determining a difficult diagnosis. —*Med. Times and Gaz.*, March 30, 1878.

Latent Gastric Sphacelus.—A curious case, interesting both from a medico-legal and a purely medical point of view, has been recorded by M. DUJARDIN-BEAUMETZ. A man, forty-seven years of age, stated that he had been attacked five days before with hæmatemesis and gastric pain. There was no tumour, nor marked gastric disturbance, a milk diet being borne without discomfort or sickness. A few aphthous-looking ulcers in the mouth puzzled the physician; but the case appeared to be one of simple gastric ulcer. In this state, without vomiting, and with but little gastric pain or sickness, the man lived for a fortnight, and then died suddenly. An autopsy revealed that the whole of the stomach, except the pyloric region, had sloughed, the necrosis involving not only the entire thickness of the wall, but also the diaphragm and omentum, so that when the slough was removed, the lung, liver, the whole spleen, and the intestine were exposed. Such a lesion could only have resulted from the action of a caustic liquid, and this explained the ulcers observed in the mouth. On inquiry it was elicited that the man had been for some time much depressed, owing to the want of employment. Just before the first hemoptysis he had retired, apparently well, and on returning had fallen on the floor, calling out that he was dead, and begging for water. Then followed the hæmatemesis. Thus there could be no doubt that he had attempted suicide by swallowing some corrosive liquid, and that he had successfully concealed the attempt, maintaining for a fortnight the appearance of health, and the apparent integrity of his digestive functions, although the greater part of the stomach was necrosed. It was apparently the separation of the slough which had determined his death.—*Lancet*, April 6, 1878.

The Treatment of Ulcers.—According to Dr. MANDELBAUM, of Odessa (*Berl. Klin. Wochenschrift*, No. 10, 1878), all ulcers of the leg and elsewhere, whatever their character, age, and extent, can be cured by the following method. If they are very deep, with much loss of tissue and with undermined, uneven, callous edges, they are first to be scraped away until healthy tissue is reached, with the modification of Volkmann's spoon as suggested by Hebra; they are then to be covered for several days with a thick layer of iodoform until fresh granulations spring up (as they are certain to do), and until the base of the ulcer has reached the level of the surrounding skin. When this point in the healing process is reached, the ulcer is to be strapped daily with equal parts of mercurial and soap plaster of rather soft consistence, and carefully and evenly applied. Shallow ulcers which are only covered with a thick layer of pus require no preliminary scraping, and can be at once treated with iodoform, and later on strapped as above described.—*Med. Times and Gaz.*, April 6, 1878.

A Caustic-Holder Swallowed.—The application of nitrate of silver to the fauces is attended sometimes with other risks than those generally recognized. According to Dr. R. DEMME, of Berne, a practitioner was lately cauterizing the tonsils of a child, five and a half years of age, with fused nitrate of silver, fixed in a silver-plated caustic-holder, four inches long, when the instrument slipped from his fingers into the pharynx, and was swallowed before he could seize it again. It appeared to pass down the œsophagus without any special difficulty or distress. Large quantities of milk, oil, and melted fat were immediately administered. For the first few days constant vomiting occurred, and subsequently brownish mucus was ejected. Gradually, however, the vomiting ceased, and solid food was again taken. The motions during this time were liquid and offensive. Nearly three weeks after the accident the caustic-holder was passed per anum, inclosed in thick masses of mucus. With the passage of the foreign body the symptoms, which continued those of alarming weakness, improved, the only remaining disturbance being the frequent occurrence of obstinate constipation. The case illustrates the great danger of making applications to the throat with a caustic-holder of insufficient length to permit of a firm grasp, especially when the patient is a struggling child.—*Lancet*, April 6, 1878.

The Vomiting of Pregnancy.—Dr. Labelski (*Presse Méd. Belge*, March 3), a physician attached to the Warsaw hospitals at the Brussels Academy of Medicine, referred to a simple and certain means for arresting the incoercible vomiting of pregnancy. As soon as this appears, or even the nausea which usually precedes it, a douche of pulverized ether should be directed by Richardson's spray-producer against the epigastric region and the corresponding part of the vertebral column. The douche should be prolonged for from three to five minutes, or even longer, and repeated every three hours. In obstinate cases it should be alternated with douches of chloroform.—*Med. Times and Gaz.*, March 16, 1878.

Thymol and its Pharmacy.—Prof. Gerrard, of University College Hospital, lately read a paper on the above subject, before the Pharmaceutical Society of Great Britain. As thymol is engaging the attention of the medical profession, especially the department of surgery, a few remarks about it may be useful. It is extracted from the essential oils obtained from the common thyme, *Thymus vulgaris;* the horsemint, *Monarda punctata;* and an Eastern drug called *Ptychotis djonan.* In commerce it consists of irregular broken crystals, nearly transparent and colourless. It has an aromatic taste. Its specific gravity when it is fused is lighter than that of water. It is a powerful antiseptic, superior to carbolic acid. The strongest permanent watery solution of thymol available is 1 in 1000 of hot water. A glycerole of thymol is available thus: 1 gr. thymol is soluble in 120 of glycerine, and can be reduced with water to 600 parts, forming a clear solution. Thymol is more expensive than carbolic acid, yet the difference is not so great when the relative quantities for use are considered. Its pleasant odour and non-poisoning property, added to its other advantages, place it far before any antiseptic at present employed.—*Medical Examiner*, March 28, 1878.

On the Administration of Cod-liver Oil.—Dr. de Penteve writes to *L'Union Médicale* to describe a method to conceal the taste of cod-liver oil and to facilitate its absorption. He mixes a teaspoonful of the oil intimately with the yolk of an egg and ten drops of tincture of peppermint, to which he adds half a glass of sugared water. He thus obtains an emulsion which differs very little from ordinary milk. There is neither the characteristic taste nor the odour of cod-liver oil, and the patients take it without the slightest feeling of repugnance. Further, the oil having been rendered miscible in water in all proportions, it is actually emulsionized, and its absorption is more certainly secured.—*Lond. Med. Record*, February 15, 1878.

California Wine.—The *Lancet* for March 16, 1878, says: "It has for some time been the opinion of competent judges that in the course of a few years California will send to the European markets wines able to bear comparison with the choicest vintages of the Rhine and the Moselle districts. At the exhibition of wines held in South Kensington a few years back, the wines took a very high place, and led many to think that California is *par excellence* the wine-growing country of the future. A paper on "The Chemical Composition of California Wines," by Mr. W. J. McAdam, will be found in the *Pharmaceutical Journal* for March 2. The results obtained were very favorable, and will tend to justify the expectations entertained regarding the quality of the wines.

A Curious Case.—A little child at Briton has been killed by accidentally swallowing a squeaking air-bladder. It appears, from information furnished by Mr. G. A. Johnson, that the toy slipped through the glottis with the bladder downwards, and the quill mouth-piece upwards, so that with every inspiration the bladder became more or less inflated, and thus prevented the entrance of air to the lungs, and produced death by suffocation. A verdict of "accidentally suffocated" was returned by the jury. The case must be unique.—*Lancet*, March 16, 1878.

Extraordinary Precocity.—M. Lefebvre (*Gaz. Hebd.*, March 8) read a report to the Belgian Academy of Medicine on a case of extraordinary precocity met with in a girl eight years of age, born at Oberpallen, Luxemburg. The child was born very fully developed, having hairs on the pubes. Menstruating at four years of age, she became pregnant at eight by a cousin thirty-seven years of age, who was sentenced to five years' imprisonment for her seduction. The pregnancy terminated by the expulsion of a mole containing a well-characterized human embryo.—*Med. Times and Gaz.*, March 16, 1878.

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A New Living Double Monster.—Heschl furnishes the description of an examination he has made at Vienna, of a living girl, seventeen years of age, who exhibits an example of a still rarer form of monstrosity than the Siamese Twins or the Two-headed Nightingale, inasmuch as in her case the formation, in place of the upper part of the body being double as in their cases, consists in a doubling of it only below the second lumbar vertebræ, the upper portion resembling that of a pleasing delicate girl of from ten to twelve years of age. The case is a specimen of Förster's *Dipygus tetrapus.*—*The Doctor*, April 1, 1878.

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The Effect of Gaslight upon the Eyes.—A report upon the effect of gaslight upon the eyes has recently been laid before the German Minister for Education by the Scientific Committee for Medical Affairs. The conclusions arrived at are that, according to present experience, gaslight has no prejudical effect upon the eyes, provided that they are sufficiently protected from its direct action. For this purpose, the committee recommend shades and bell-glasses of translucent glass-porcelain. On the other hand, they disapprove of opaque metallic shades, since, when these are used, the eyes, though themselves in shade, gaze upon a strongly-illumined surface, and become dazzled and overstimulated. On account of the large quantity of heat involved by gas, the burner should not be too near to the heads of persons in the room; the heat is liable to cause headache, and even congestion of the brain. Care should also be taken to prevent the flame from flickering, which is often a source of mischief and annoyance. Where there is any particular irritable condition of the eyes, a dark-blue glass will be found advantageous. The committee believe that with these precautions gaslight may be used without fear of mischief.—*Med. Examiner*, March 28, 1878.

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The Royal College of Physicians and Medical Women.—An extraordinary meeting of the Royal College of Physicians was held on the 18th of March "to consider whether, under any circumstances, the Royal College of Physicians of London is prepared to grant its license to practice physic to women." The following resolution, proposed by Sir George Burrows and seconded by Dr. West, was adopted by an overwhelming majority, "That the Royal College of Physicians, having considered the important question of granting licenses to practice physic to women, resolves, 'That the College do steadily adhere to the terms of its charter, and do not grant licenses to practice physic to women.'"—*Med. Times and Gaz.*, March 23.

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Sir William Jenner and the British Medical Association.—We learn from the *Lancet* (March 2, 1878) that Sir William Jenner has sent in his resignation as a member of the British Medical Association on the ground of the share women are allowed to take in its proceedings. Sir William, it is stated, has, however, consented to postpone his actual retirement until the Council has deliberated as to the course of action it may see fit to take.

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Professor Schwann.—*Nature* for March 28th announces that in a few weeks a festival will be held in the city of Liege to celebrate the fortieth year of the professorship of Theodore Schwann, the author of the cell theory. Many persons will be surprised to learn that the founder of modern histology is not only alive, but is at the present moment actually teaching as professor of physiology in the Belgian University.—*Lancet*, April 6, 1878.

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CLINICAL LECTURES.

ON CHRONIC CYSTITIS AND ITS TREATMENT BY INJECTIONS OF STRONG SOLUTIONS OF NITRATE OF SILVER.

By T. G. RICHARDSON, M.D.,
Professor of Surgery in the Medical Department of the University of Louisiana.

Delivered at the Charity Hospital, New Orleans.

GENTLEMEN: Those of you who have accompanied me through the surgical wards during the past few weeks have had the opportunity of seeing a number of cases of chronic cystitis, and of witnessing the results of the remedial measures employed in each. Without entering into the details of the histories of these cases, I propose, this morning, to use them as a text for a few remarks upon the disease in general, and its management.

Chronic cystitis, as you have already learned by observation, is by no means an uncommon malady, and is in this respect in marked contrast with the acute form, which is comparatively rare. It is far more frequently seen in the male than in the female, although some of the most intractable cases which have come into my hands have been in the latter sex. Except when associated in children with calculus, or some other foreign substance in the cavity of the bladder, it is almost

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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altogether a disease of adult life. Its seat is the mucous membrane of the bladder, from which it may extend to the other tissues of the organ, and along the lining of the ureters to the pelves and uriniferous tubules of the kidneys.

The *Causes* of chronic cystitis are very various, and as they determine in a large proportion of cases the mode of treatment which should be employed, I must call your attention to those most commonly observed.

1. Chronic cystitis may be a sequel of acute inflammation.

2. Notwithstanding the fact that the mucous membrane of the bladder is constantly in contact with a fluid which in relation to most of the tissues of the body is a decided irritant, the presence of a calculus or other foreign substance is resented with almost as much commotion as the entrance of a strange insect into a hive of bees; and, as in the latter instance, reconciliation is impossible so long as the intruder remains within the hive, so in the former the excitement continues until the offending substance is removed or expelled, and sometimes even for an indefinite time thereafter. It matters not that the stone enters quietly through the ureter in the form of a minute gravel, and attains its growth by slow degrees, or, as is sometimes the case, that it is so smooth as to glide about from one corner to another without appreciable friction; the organ rarely if ever consents quietly to its stay. You may readily imagine how much greater the disturbance produced when the offender is a rough prickly concretion of oxalate of lime, such as I show you here, or the jointed vertebræ of a squirrel's tail (introduced from without, of course), partially incrusted by phosphatic deposits, as you see in this other specimen. In certain localities, as, for instance, the State of Tennessee and the adjacent parts of the contiguous States, calculus is probably the most common cause of chronic cystitis, but elsewhere in this country it occupies a subordinate place.

3. Undoubtedly the most universal cause of the disease in question is obstruction to the complete evacuation of the bladder. This may result from stricture of the urethra, hypertrophy of the prostate, transverse bar at the neck of the bladder, lodgment of calculus or other foreign body in the urethra, etc. etc. In the first two of these conditions there is an additional liability arising from an extension of inflammation from the stricture or the enlarged prostate. The manner in which obstruction leads to inflammation requires a little explanation.

There is in health always more or less mucus in the urine, arising from the natural action of the lining membrane of the bladder, but the quantity is so small as to pass unnoticed in ordinary examinations. Nevertheless, it may sometimes be detected by allowing the fluid to stand for a few hours in a test tube, when it will be found to have settled in a slight cloud at the bottom. Where obstruction exists the protracted and violent effort to empty the bladder induces an increased secretion of mucus, which gravitates to the base of the organ. Now, bear in mind that the trigone in the male after middle life is a little below the level of the orifice of the neck of the organ, and is nearly fixed in its position, so that during micturition it *does not participate in the general contraction of the walls.* Any mucus having settled here is very likely, therefore, to remain in place after micturition, more especially as patients labouring under obstruction generally stop short of the complete performance of this function from the fatigue and pain which the effort induces. The mucus which thus collects in the basin of the *bas fond* undergoes decomposition, and having thereby become acrid and irritating awakens inflammation of the mucous membrane already in a state of excitement and active congestion from the frequent and violent endeavours of the individual to relieve himself. Inflammation having been lighted up, pus is added to the mucus already largely increased in quantity from the same cause, and thus by the supply of more material the putrefactive processes are rendered more vigorous, and their products more abundant and irritating.

4. Injuries of the spine producing complete or only partial paralysis are almost

invariably followed by chronic cystitis. Not unfrequently the immediate cause of the inflammation in these cases is the injury inflicted upon the bladder by the overstretching of its walls from the retention of urine which results from such accidents. But even in cases where the medical attendant is upon his guard, and takes the precaution to draw off the urine by means of a catheter, and repeat this operation at proper intervals, evidences of morbid action are almost certain to appear within two or three days. The explanation may possibly be found in the passive congestion of the mucous membrane arising from loss of nerve power, and the impracticability of emptying the bladder by ordinary catheterism when its walls are in a flaccid condition. Under other circumstances, that is to say, when no paralysis exists, the withdrawal of the urine by the catheter is attended by contraction of the vesical walls, by which means all the fluid is expelled from the cavity. But, on the contrary, in such cases as we are now considering, and of which you have a marked example in ward 6, the urine being forced out by the pressure of the abdominal viscera and the temporary contraction of the abdominal muscles, the walls of the organ are crowded in upon themselves forming irregular folds between which more or less urine is always retained. The mucus which is, of course, largely increased in quantity by the atonic congestion, settles to the bottom whence it is only partially removed by the catheter, the remainder undergoing putrefactive decomposition which, by its reaction, increases the inflammatory action, as in the previous case.

5. Excessive alkalinity or acidity of the urine are said to produce chronic cystitis, but I am inclined to think that in such cases the morbid action is due principally to the deposition of the solid constituents of the fluid, rather than to the chemical effect of the latter upon the mucous membrane. This membrane being physiologically proof against harm from the varying qualities of the urine within the range of health, will often bear without resentment the contact of fluids of a tolerably pungent or acrid quality, while, on the contrary, as I have already stated, it rebels instantly and continuously against the lodgment of any solid substance, however simple, within its walls. From my own experience, I am led to believe that a close examination of the urine—or rather of the urinal—in such cases will always disclose sedimentary deposits in greater or less abundance. This is particularly true in reference to urine which is excessively alkaline, in which phosphatic deposits in the form of minute seed-like concretions sometimes occur, and become the cause of inflammatory excitement. These alkaline deposits are, doubtless, very often the *result* of the inflammation rather than the *cause*, and it is no easy matter always to distinguish between the two.

Morbid Anatomy. — The structural changes induced by chronic cystitis consist primarily in thickening and increased vascularity of the mucous membrane, in which, however, there is nothing peculiar, inasmuch as the same takes place in nearly all other similar membranes when invaded by chronic inflammation. The mucous follicles are, of course, much enlarged, and secrete, sometimes, a wonderful amount of viscid ropy mucus.

The most striking alteration, however, is seen in the muscular tunic, which in all cases of long standing is more or less hypertrophied, and projects into the cavity of the organ in the form of a very coarse netting, in the interstices of which the mucous membrane is depressed, forming shallow crypts or lacunæ, of various sizes, from that of a hempseed to that of a filbert. In very bad cases, the greatly thickened muscular bundles look not unlike the *columnæ carneæ* of the cardiac ventricles, and are characteristic of what some surgeons term columnar vesical hypertrophy. Under these circumstances the cavity of the organ is greatly reduced in its capacity, sometimes to such a degree, as you have seen in the case of the patient in ward 14, that it can contain only an ounce of urine, or even less. The walls themselves frequently measure an inch in thickness, as in the specimen I show you here. Associated with this remarkable hypertrophy of the muscular coat, we not unfrequently observe that the little shallow crypts formed in the interstices of the muscular bundles become very much deeper, and, in some instances, form hernia-like protrusions upon the outer face of the bladder, varying in diameter from that of a pea to that of a pullet's egg. When these become quite large the organ is said to be sacculated. Occasionally, one of these so-called herniæ will continue to enlarge until its capacity equals, or even surpasses, that of the bladder, with which it communicates by a comparatively small opening. An illustration of this is seen in the specimen upon the dish before you, which is, to all appearances, a double bladder, the two compartments communicating through an aperture not larger than a No. 7 or 8 catheter. I know nothing of the history of the case from which this interesting specimen was taken, save that the patient, a poor, simple-minded, emaciated, old countryman, entered the hospital for general debility, presenting also a urinary fistula leading from the umbilicus along the line of the urachus to the fundus of the bladder; and that he died within a very few days afterward, before any satisfactory history could be obtained.

This hypertrophied condition of the muscular coat of which we are speaking is readily explained in most cases by the frequent and violent contractions of the bladder in its efforts to overcome a persistent obstruction to the exit of the urine. But it is not limited to such cases, for it is sometimes met with in chronic cystitis where no obstacle exists. This is well illustrated in the patient already referred to in ward 14, in whom, so far as I can ascertain, no difficulty in emptying the organ has ever existed, and in whom a No. 12 bougie may be readily passed. In this and other similar instances violent spasmodic contractions are of frequent occurrence daily in consequence of the excessive sensibility of the inflamed mucous membrane, and in the course of time give rise to the same condition of muscular hypertrophy as in the former cases.

In connection with these pathological conditions of the bladder itself, I must not neglect to call your attention for one moment at least to the serious changes which sometimes take place in the ureters and kidneys in consequence of an extension of the inflammation in this direction. Such extension is by no means rare, and commonly results not only in great thickening and induration of the walls of the ureters, but destructive ulceration and abscess of the kidneys. This is more particularly the case where the inflammation is caused and maintained by protracted obstruction to the discharge of the urine from the bladder.

Before leaving this branch of the subject, permit me to impress upon your minds the importance of a knowledge of the morbid changes upon which I have been descanting. Upon their existence or non-existence in any given case will depend to a large extent its curability or incurability.

The *Symptoms* usually presented by chronic cystitis are so well marked as to render its detection tolerably easy; but owing to the fact that the affection is sometimes simulated in hysteria, and at other times masked by concurrent diseases of the adjoining organs, it is desirable always to obtain as accurate a history of each case as possible. Without this, indeed, it is scarcely possible to appreciate the different phases which it assumes in consequence of the differences in the causes by which it is produced. The two immediate signs, however, upon which we mainly rely are, 1st, inability of the patient to retain his water longer than a few minutes, or, at most, an hour or two; 2d, the presence of tenacious mucus, mixed with more or less pus, in the urine; and, 3d, vesical tenesmus.

The first of these evidences, that is to say, the pressing and frequently recurring desire to empty the bladder, is often observed in other conditions, such as irritation at the neck of the bladder from gleet, from the lodgment of gravel in the prostatic urethra, from mental anxiety, from a morbid state of the urine, from the presence of ascarides in the rectum, from vaginitis, cervicitis, and other inflammatory states of the adjacent organs of the female, and from numerous other causes which I need not here mention. On the other hand, it may be almost entirely wanting, of which I have just now a most remarkable instance in a private patient who, although for a long time a subject of the disease, has always been able to carry his water five or six hours without special inconvenience. Nevertheless the symptom is an important one, and should be carefully investigated.

The appearance of thick viscid mucus in the urine is almost pathognomonic of chronic cystitis. It is usually quite abundant, almost transparent, except when mixed with pus, and so tenacious that it clings to the bottom of the vessel in long stringy masses while the urine is poured off, and then, if the vessel is smooth, suddenly slips away like a mass of half-coagulated jelly. The quantity of this secretion is sometimes very great, and in such cases the disease is frequently denominated *vesical catarrh*, a term which it seems to me is entirely unnecessary, and likely to mislead the student. As mucus of this description in the urine can come only from the lining membrane of the bladder, and is necessarily the result of chronic inflammation, you see very clearly how important it is in a diagnostic point of view. And here I take the opportunity of saying that *when this secretion is wanting true chronic cystitis does not exist.* In making this assertion I am well aware that I run counter to the opinions of many excellent surgeons who, under the abominable term of *irritable bladder*, recognize a species of chronic inflammation in which little or none of the usual glutinous mucus is secreted; but I can scarcely do otherwise, inasmuch as I have never seen and can scarcely imagine such a case. The morbid condition to which this name has been applied may be one of chronic inflammation of the lining membrane of the neck of the bladder, extending, possibly, a very little way into the body of the organ; but, to my mind, this is quite as distinct from chronic cystitis as chronic laryngitis is from chronic bronchitis. But in the majority of cases the irritable bladder is no disease at all, but only a symptom of trouble elsewhere; it may be in the nervous system, in the rectum, in the kidneys, or in the urethra.

As already stated, there is very commonly mixed with the mucus more or less pus, which settles to the bottom along with the latter, as you see well exhibited in this glass, the contents of which were passed by the patient in ward 8. Oftentimes the pus is so abundant as to conceal the mucus from view until the supernatant fluid is poured off, when the ropiness of the latter readily discloses its presence.

Large quantities of phosphates are not unfrequently observed in the mucus to which they impart a whitish slimy appearance, not unlike that of thin mortar. When this is the case, the urine is, of course, strongly alkaline, and gives off a powerful ammoniacal smell.

The vesical tenesmus which has been mentioned as an accompaniment of chronic cystitis is not characteristic, but often a most distressing symptom, seizing the patient suddenly, and not relaxing its painful grip until the last drop of water is expelled. It well deserves to be called *vesical cramp;* and when it occurs repeatedly every day for a great length of time is sure to result in hypertrophy of the muscular coat, of which it then becomes an important symptom.

The general health is not necessarily seriously impaired by chronic cystitis, unless the disease is associated with other morbid conditions, or is attended with constantly recurring tenesmus. In the latter case the system may give way in consequence of the suffering, especially in the case of old men with enlarged prostate. On the contrary, the worst case of this disease which I have ever encountered, a case in which the patient is unable to retain his urine longer than five or six minutes, and in whom tenesmus occurs many times during the day, is that of a man in middle life whose general health continues most excellent now after six or eight years of suffering.

Diagnosis.—Bearing in mind the symptoms which have just been detailed, you can scarcely err in determining the presence of chronic inflammation of the bladder; but it is not always so easy to discover its cause. As without a knowledge of the latter it is impossible to pronounce a rational prognosis or institute suitable treatment, it is of the first importance that this question should be satisfactorily settled. For this purpose the history of the case should be accurately ascertained. If the disease succeeded to an injury of the spine, resulting in paralysis of the lower half of the body, there can be no doubt that the accident was the essential cause. If it was immediately preceded by gleet, the probability is that it was induced by an extension of inflammation from the latter, and is kept up by stricture of the urethra, and consequent inability to empty the bladder entirely. The urethra should be examined with a bougie under such circumstances in order to ascertain whether such is the case. If no stricture should be found, the examination should extend to the bladder itself, and thorough search made to determine whether calculus does not exist. If the patient is an old man, who relates that he has had great difficulty in emptying the bladder for several years, and that of late stringy mucus has made its appearance, the natural suspicion is that a hypertrophied prostate is the source of the trouble. This can be determined, of course, by the finger in the rectum, and a metallic bougie in the bladder. Not very unfrequently calculus and enlarged prostate coexist. None of these causes having been discovered, attention should be directed to the condition of the urine, for, as already stated, it occasionally happens that excessive acidity or, more frequently, excessive alkalinity may give rise to the disease. Without dwelling longer upon this point, permit me to say that in nearly all cases of chronic cystitis careful exploration of the bladder and urethra by means of a metallic bougie is necessary. Even though no calculus, stricture, or enlarged prostate should be detected, valuable information is obtained as to the condition of the mucous membrane, and a hitherto unsuspected tumour of the bladder may be detected. It is also equally incumbent upon the surgeon to examine the urine, for aside from the effect which may be produced upon the bladder by morbid states of this fluid, it is by this means alone that we are enabled to ascertain whether the kidneys have become implicated in the inflammation. Extension of the morbid action to these organs by way of the ureters is, unfortunately, not a very rare occurrence; and, when such is the case, there can be but little expectation of permanent benefit by treatment. If albumen should be present in large quantities, there can be scarcely a doubt as to the existence of this serious complication; much less if great numbers of tubular casts should be discovered by the microscope. On the contrary, I have recently seen a case in consultation in which large quantities of albumen existed in the urine, but which disappeared almost entirely after the removal from the bladder of a calculus upon which the accompanying cystitis depended.

The *Prognosis* of chronic cystitis in relation to the life of the individual is nearly always favourable, except in those cases where the health has been broken down by previous disease, neglect, bad habits, want of proper food, old age, or other similar causes; or where the inflammation has reached and taken firm hold of the kidneys. In the last-mentioned condition death is inevitable after a longer or shorter interval. What I wish to say is that there is nothing in the disease itself which seriously compromises the life of the patient.

The question as to the curability of the affection is a totally different one, and can be answered satisfactorily only in reference to specified cases. I may state, however, in general terms, that where there is a fair condition of health, no serious disease of the kidneys or surrounding parts, little or no hypertrophy of the muscular coat of the bladder, and *the cause removable*, the prospect of recovery is very good.

Treatment. — It is scarcely necessary that I should tell you that in the treatment of chronic cystitis, as in that of a great many other surgical affections, the first indication is to remove the exciting cause. Fortunately, in a large number of cases, as for instance in those dependent upon the presence of calculus or other foreign substance in the bladder, of stricture of the urethra or of excessive alkalinity of the urine, this is entirely practicable, and when it is accomplished the rapidity with which the morbid action subsides is sometimes truly astonishing. In calculus and phosphatic urine, nothing more is usually necessary, although it does occasionally happen, especially in old people, that the anatomical changes resulting from the long persistence of the inflammation continue to vex the patient long after the original source of trouble has been corrected. Where this is the case the special line of treatment which I am about to describe will frequently prove successful.

Resolution of the inflammation does not so often follow the dilatation of old stricture notwithstanding the fact that the bladder is thus enabled to empty itself completely. This is due principally to the hypertrophy of the muscular coat which has occurred in consequence of the accompanying tenesmus. Where such alteration has taken place, only palliation should be expected, and the patient may be obliged to wear a rubber urinal all the rest of his days. But as it is not always possible to determine in advance the existence of such a degree of hypertrophy, I make it a rule to subject all such patients to the curative treatment, trusting that some of these may thereby be materially benefited.

If the disease is dependent upon enlargement of the prostate gland as we so often see in old men, the state of affairs is in some respects like that met with in stricture of the urethra, with the difference that in the latter we have some expectation of getting rid of the producing cause, while in the former we have no such hope. Nevertheless by the daily introduction of a large-sized catheter, washing out the organ occasionally with some stimulating astringent, such as nitric, or better, hydrochloric acid, two drops to the ounce of water, and the internal administration of balsam copaiba, the inflammation may often be subdued. If these remedies should fail, the heroic treatment presently to be described should be resorted to.

And now I take pleasure in exhibiting to you again the patient, from ward 8, for the purpose of illustrating my further remarks.

This man, as you are aware, has been the subject of severe stricture of the urethra for several years, and presented, until very recently, all the symptoms of confirmed chronic cystitis. When I took charge of the ward, a few weeks ago, the stricture had been pretty well dilated by my predecessor, so that a No. 9 bougie could be slowly introduced by the patient himself, any undue haste inducing severe tenesmus. The symptoms of cystitis, however, had not much abated. His desire to urinate was incessant, and it was only by great effort accompanied by much suffering that he could restrain the evacuation for an hour at a time. While he was in bed he was compelled to keep a urinal between his thighs continually, otherwise he was not able to sleep for frequent necessity of rising. The urine, upon standing, as you have just now seen, separated into two parts, the upper tolerably clear, the lower opaque, thick, tenacious, yellowish in colour, and loaded with phosphates. Upon decanting the former, the latter, you noticed, clung in stringy masses to the bottom of the glass, and upon close inspection was found to consist of mucus and pus. Vesical tenesmus was not very frequent, although at times severe. Introduction of the finger into the rectum was productive of so much pain that the attempt to ascertain thus the thickness of the walls of the bladder was not satisfactory.

He was first put upon the use of copaiba and cubebs, which of all the internal remedies employed by surgeons in such cases hold deservedly, in my estimation, the highest place. In private practice I am in the habit of using an unofficinal preparation known as the compound extract of cubebs and copaiba, which is nothing more than solidified balsam combined with powdered cubebs and some other minor ingredients, and made into a paste which is not disagreeable to take. Of this a pill of 20 or 25 grains may be swallowed two or three times a day. In whatever manner the two remedies may be combined, they not unfrequently disturb the stomach and bowels, and require the addition of a little opium and tannin. The best time to take the remedy is about two hours after eating. The effect upon the local symptoms is sometimes truly magical, and the patient passes in a few hours from a state of despondency to one of decided exhilaration in consequence of the great and sudden relief from painful micturition. By continuing these remedies for two or three weeks, employing at the same time a general tonic course if necessary, a cure may be sometimes produced, or, at any rate, such a degree of amelioration as to fully satisfy the expectations of the patient. I have sometimes thought that the addition of bicarbonate of potassa increased the efficacy of the medicine, but am not quite sure upon this point. I have not much confidence in uva ursi, notwithstanding it is so highly commended by my venerable private preceptor, Professor Gross, and still less in buchu. I have had no experience with cimicifuga, pareira brava, triticum repens, or matico.

If the copaiba and cubebs alone or in connection with the other means just enumerated should fail, as has happened in the case before us, local applications by injection are called for. For this purpose the following remedies may be employed in quantities sufficient to wash out the bladder thoroughly: nitric or hydrochloric acid (♏j to f℥j), liq. sodæ chlorinat. (♏x to f℥j), carbolic acid (grs. v to f℥j), tannic acid (℈ss to f℥j). I have tried all of these repeatedly, and a great many other washes, but except in very mild cases, and as an adjuvant to the cubebs and copaiba, have laid them aside. The remedy upon which I now rely almost exclusively is nitrate of silver in solutions of such strength as will make a decided impression upon the inflamed membrane. Those of you who are aware of the great caution advised by nearly all surgical writers and teachers in reference to the use of this salt as an injection into the bladder, and their timid recommendation of a solution not stronger than *half a grain to four ounces of fluid*,[1] have doubtless been somewhat startled when you have seen twenty grains, thirty grains, and forty grains to a single ounce of water thrown into the organ with impunity, and with decided benefit to the patient. It is now nearly twenty years since I recognized the absurdity of weak solutions, having remarked that they no sooner reached the bladder than they were immediately decomposed and thus rendered entirely inert by the few drops of urine which they are always sure to encounter there despite the most thorough irrigation and the most rapid change of apparatus. Aside from this, I could see no good reason why the mucous coat of the bladder should be an exception to all other similar structures, such, for instance, as the conjunctiva, the lining membrane of the fauces, the larynx, the trachea, and the uterus, to which surgeons are in the habit of applying not simply strong solutions but the solid salt itself. It seemed to me that it was only necessary to provide for the quick withdrawal of the fluid or its rapid decomposition, after allowing it to remain in contact with the inflamed surface for a few seconds, and no damage could occur from solutions even stronger than those already mentioned. After considering the question from this point of view, the first case that came into my hands was that of a young man, who several months previously had suffered paralysis of the lower half of the body, including the bladder, from spinal injury. The paraplegia had entirely disappeared, but the cystitis, which had resulted from neglected retention of urine, was unabated, and he had not the slightest control of the function of micturition, the water dribbling from him continually. After washing out the cavity thoroughly

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[1] This is the strength of the solution recommended by Sir Henry Thompson, and repeated in nearly all the recent text-books on surgery. To prove its entire inefficiency I requested Mr. Johnson, the house chemist, to determine the relative incompatibility of urine and nitrate of silver, and he has shown by a number of experiments that 100 minims of the former of average quality will decompose 2.100 grs. of the latter. Now when it is borne in mind that urine enters the bladder ordinarily at the rate of 18 or 20 minims per minute, that this quantity is largely increased by the reflex action upon the kidneys induced by the passage of instruments along the urethra, that it is impossible to free the bladder entirely of urine even for an instant, and that a certain delay is necessary in making the injection, it seems to me no one can doubt, that the injection must meet with not less than 20 to 30 minims of urine which will decompose instantly not less than .700 of a grain of the salt.

I injected an ounce of a solution ℈ij to f℥j, permitted it to remain about ten seconds, and followed its withdrawal by an injection of a solution of iodide of potassium in order to decompose any of the former which failed to escape through the catheter. After a week or ten days sufficient improvement was manifested to justify a repetition of the operation. I then used the same quantity of a solution of the strength of ʒj to f℥j. The effect was all that could be desired. The symptoms improved within three or four days, and in less than a fortnight the patient returned to his home in Alabama entirely cured.

Before entering into further details, permit me to impress upon you two or three points of paramount importance in the use of this remedy. First of all *be sure that you are dealing with a case of genuine chronic cystitis.* Simulation of the disease, as already stated, is not uncommon in hysterical women, and irritation of the surrounding parts sometimes gives rise to symptoms which may mislead the unwary. Especially guard against the mistake of considering what is termed "irritable bladder" a condition of inflammation of the organ. You may rest assured, that, where a tolerably abundant discharge of vesical mucus is wanting, chronic cystitis does not exist. In the second place, be equally certain that the exciting cause has been removed, or at least so modified as to exert no further influence upon the disease. And, in the last place, never undertake this method of treatment unless the urethra is sufficiently large to readily admit a No. 9 or 10 catheter.

The only other instrument required besides a catheter of the size just mentioned is an elastic bag capable of holding one or two fluidounces, and provided with a bone or hard rubber nozzle well fitted to the former.

My custom is to begin with a 20 grain solution of the temperature of the body, using at least an ounce, so as to reach the entire surface of the interior of the organ. If no decided improvement should occur in the course of a week or ten days, the injection should be repeated, increasing the strength of the solution to thirty grains. No impression having been made by this last, the strength may be further increased, until a drachm to the ounce has been attained.

An important point to determine is the length of time the solution should be allowed to remain in the bladder. This must vary somewhat in different cases. If severe pain is instantly produced, two or three seconds is long enough for the first injection. If, on the contrary, the suffering is not considerable, eight or ten seconds may be allowed to elapse.

To remove the fluid it is only requisite to keep the nozzle of the bag closely pressed into the mouth of the catheter, and to relax the grasp of the hand upon the former. In this way nearly the whole of the fluid will be drawn back into the bag, and the remainder will readily escape by turning the patient upon his side.

We shall now proceed to perform the operation. The patient has been already injected once with a twenty grain solution about a fortnight since in the ward, and we propose to increase the strength now to thirty grains.

No anæsthetic will be given, for by doing so we should fail to obtain the information which we desire in regard to the sensitiveness of the organ when the injection reaches it.

You observe that the catheter is passed with some little difficulty, owing to the stricture which is not yet fully dilated, and that the urethra is very tender. Now that it is fairly in you see mucus and pus issuing from its mouth. By means of the rubber bag we next throw in an ounce or two of tepid water, and allow it to escape. In doing this, forcible distension of the organ should be studiously avoided. While the water is flowing out of the catheter the bag is filled with the solution, and as soon as all the water is forced out by pressure made with the hand above the pubes the nozzle is tightly pressed into the catheter, and the bag immediately, but not suddenly, compressed. The pain is not excessive, but as six or eight seconds have elapsed, pressure upon the bag is relaxed, and nearly all the fluid is withdrawn. Upon squeezing it out into the bowl you notice that it has a very decided milky appearance, which is due to the partial decomposition which it has undergone in the bladder. Urine is constantly entering the cavity from the ureters, and, be as prompt as you may in the performance of the operation, a considerable portion of the nitrate is converted into chloride which is entirely inert. As already stated, I was formerly in the habit of following the injection by a solution of iodide of potassium, for the purpose of neutralizing the small quantity of the solution which is left behind, but this is entirely unnecessary, the urine which enters the organ proving quite as effective.

As you may readily suppose, the operation is followed by more or less tenesmus, and it is sometimes necessary to resort to a slight hypodermic injection of morphia, but ordinarily the pain subsides in the course of an hour or two, under the use of diluent drinks, aided, if necessary, by a warm hip-bath.[1]

As it is my desire to give you a perfectly ingenuous account of my experience in the use of strong solutions of nitrate of silver, I cannot bring this lecture to a close without calling your attention again to the man in ward 14, in whom these injections have been made without the slightest benefit, and upon whom, as a last resort, I performed the operation of cystotomy with no better success.

From the history of the case, written by the patient himself, it is evident that he suffered from chronic cystitis as far back as 1861, resulting from sunstroke and retention of urine. He had not entirely recovered from this in 1871, when he contracted gonorrhœa, and when nearly well, as he supposed, had retention of urine. An attempt was made to pass a catheter by a drunken doctor, who after severely lacerating the urethra abandoned the case to nature. The retention continued for thirty-two hours, when the patient passed into a delirious state, during which he does not know what occurred, and from which he recovered several weeks afterwards, to find himself unable to hold his water longer than a few moments at a time. Since then he has been treated by several physicians, some of them excellent practitioners, but without improvement.

He came into my hands a month or six weeks ago, apparently in good general health. The history of the case and the muco-purulent state of the urine afforded abundant evidence of the existence of chronic cystitis. Exploration with a metallic bougie showed that there was neither calculus of the bladder nor stricture of the urethra, but demonstrated excessive sensitiveness of the vesical mucous membrane, and probable columnar condition of the muscular coat. The bladder could not retain more than half an ounce of fluid without exciting severe tenesmus, and the patient was therefore compelled to wear a caoutchouc urinal. As the long duration of the case, the frequent tenesmus, and the evidence obtained by exploration rendered it more than probable that the hypertrophy of the muscular coat was considerable, I was unable to give the man any encouragement as to treatment. Nevertheless, as he was unwilling to return home without some attempt having been made to alleviate his distressing condition, and hoping that some benefit might possibly be conferred, I placed him upon the internal use of copaiba, cubebs, and belladonna, and injected his bladder in the usual way, three times, at intervals of a week, with the thirty grain solution. No good having been accomplished I suggested cystotomy, as a means of placing the bladder completely at rest for a given time, and permitting the further application of local remedies, but I explained that it would prove of no avail if the hypertrophy of the muscular coat should be found as great as I feared, and the extreme contraction of the bladder permanent. Like a drowning man, the patient grasped the slight hope that was thus held out, and in due time what is known as the lateral operation of lithotomy was performed in your presence. Upon introducing my finger through the wound into the bladder my fears as to the condition of the muscular coat and the rigidly contracted state of the bladder were more than realized, as I then announced to you. As usual in such cases, there was considerable hemorrhage from the dilated veins around the neck of the bladder, and I was obliged therefore to keep the wound firmly plugged around a canula for five or six days. Two injections each of twenty grains of nitrate of silver were subsequently made through the wound, and the latter kept open for five or six weeks. Notwithstanding the free escape of the urine there was no relief from the vesical tenesmus except by large doses of morphia. The patient is now entirely well of the operation, but the condition of the bladder is unchanged, and will probably continue so indefinitely. In the mean time the man's general health is most excellent, better than it has been for several years.

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[1] The patient upon whom this operation was performed was so much improved that he left the hospital ten days afterwards in search of work. He has reported at my office once since then, and expressed himself as still doing well.

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Summer Prurigo; Prurigo Æstivalis, seu Prurigo Adolescentium, seu Acne-Prurigo. By Jonathan Hutchinson, F.R.C.S., Senior Surgeon to the London Hospital and to the Hospital for the Diseases of the Skin, etc.—(*Concluded from* p. 74.)

I will now read to you brief detached notes of some other cases which illustrate my assertions respecting this class of affections:—

A sugar refiner from Whitechapel, named Samuel H., was under care in July, 1870, for a pruriginous eruption on the legs, forearms, and face, which he said always got well in winter. There were a few vesicles mixed with the prurigo spots.

Mary A., a married woman, aged twenty-nine, suffered for a second time during the summer of 1870, from a pruriginous eruption on the arms, chest, thighs, and legs. It affected her face slightly. It has been well in the winter.

William H., a coke dealer, aged twenty-four, came under care in March, 1870, having then suffered from relapsing prurigo for six years. The eruption was to some extent eczematous, and although it affected the backs of the limbs most severely, the flexures were not quite exempt. He considered that it was worse in spring and autumn, but it never got quite well either in winter or summer. The skin of the lower extremities was rough and dry, and the eruption bore evidence of much scratching. His face was free when I saw him, but it had formerly been affected. The eruption, which was almost general, was only slight on the chest. He asserted that the little red spots, which were the first stage of the eruption, became white when rubbed. A sister and himself had suffered from "bad heads" in childhood, but in the interval he had been quite well, and his sister still remained so.

I cannot state the termination of this case. In some features it resembles a case of pruriginous eczema which I shall have to relate hereafter, in which, after several years of suffering, death occurred.

A girl named Sarah S , aged fourteen, under care in 1869, had a symmetrical papular eruption covering the face, arms, and hands. It was just like Charles P.'s, and was more severe on the face than elsewhere, and affected the backs of the arms more than the fronts. The itching was only slight. It was quite symmetrical, and had been present with summer relapses for three years. It was stated that two of her brothers older than herself had suffered from a similar rash for about the same time.

This history might suggest the probable existence of a parasitic cause, but the severity with which the face suffered seemed to negative this. After two months' attendance under treatment by arsenic and the lead and mercury ointment the notes state that she was nearly well.

Robert S., a harness maker, aged nineteen, attended at the hospital in August, 1869. His eruption was a prurigo, and was, he said, always worst in hot weather and almost well in winter. It occurred chiefly on the arms, but was present also on the trunk and outsides of thighs. He did not wear woollen next the skin. The notes do not state how long he had suffered, but imply a duration of several years. We found pediculi on the head, but none in the clothes.

My next case is one of the longest duration which I have to mention, the patient having suffered for twenty years; still, however, it had not begun in infancy, and it was a summer rash, not a winter one.

Mary Ann W., aged thirty-three, a widow, applied in July, 1869. She had suffered from her eruption every summer since she was thirteen years of age. She was most positive as to the influence of season, asserting that she was always well in winter. She inherited gout, and had suffered from a single attack last winter. The eruption covered thickly the fronts and backs of the arms, backs of elbows, and backs of hands. There were some spots on the forehead, and a considerable number on the fronts of the thighs and legs. It did not occur at the flexures. The case differed from most others which I have seen, in that the face was but slightly affected. The woman described the itching as having been considerable at times, but the disease did not by any means appear to have embittered her life. She had been married and had borne children, and had never observed that the eruption was worse during pregnancy or lactation. She was stout, but not florid.

A girl named Jane B., aged twenty-two, was under care in September, 1869, for a copious eruption on the face, which had been much scratched, and which differed from acne in that the whole skin of the face was more or less inflamed, whilst there were no comedones and no pustules. My notes state that it was exactly like Charles P.'s case. She had a few spots on the backs of the hands, and had formerly had it on the legs also. She had been liable to the eruption on the face for five years, and had always been much worse in summer. A year previously she had been under care at Guy's. At the time of her application at Blackfriars, the eruption was complicated by urticaria, the wheals of which were as large as half-pence (possibly from bites). She took arsenic, and used a lead and mercury ointment, and in a month was "a good deal better."

The following case, although an example of severe and long-persistent prurigo, differs from Hebra's type in that the face was first affected and always suffered most severely, that the eruption got almost well in winter, and that it did not begin till the age of eight.

Harriet A., a milliner, aged seventeen, first came under our notice on June 25, 1869. She was then suffering from an eruption which affected the face, arms, and to a slight extent the chest, but from which other parts of the body were free. It was stated to have first appeared when she was eight years old, and to have then shown itself on the arms and face. Her face was now covered by an eruption in part papular and in part eczematous, and it was raw from scratching. On the arms the papules looked exactly like those of prurigo senilis (from lice). No wheals could be found, but she stated that the spots "began as bumps." There were no vesicles nor any papules which were free from evidences of scratching. Her mother spoke positively as to there having been no eruption in infancy or after vaccination. Two other older children and seven younger had remained free from skin disease. As a rule, it was asserted the skin would become quite clear in winter, but during the last winter she did not quite lose the eruption. My notes state that the eruption exactly resembled Charles P.'s. There were no spots on the fronts of elbows, but few on the fronts of arms, and not many on the shoulders. On the backs of the hands it came as low as the knuckles. We were told that on one occasion she was two months at the seaside and got quite well. Arsenic, in three-minim doses, was prescribed, and a lead and mercury ointment, and was continued with intermission for more than a year. My last note is July 21, 1871, that is, two years after her admission. She considered that she had on the whole been better for the treatment, but she had varied much, and had never been quite well on the face. When the arsenic was given in six-minim doses the eruption improved, but the remedy disagreed with her stomach. Tar lotions and the bismuth lotion had also been tried. The eruption had always been at its worst in hot weather.

Catherine D., aged sixteen, came under care in June, 1871, with an eruption of "lichen prurigo," which affected her face, forehead, backs of forearms and arms, and front of chest. This was her second attack, and had lasted one month. Her first had occurred just a year ago, had lasted all the summer, and got well when the cold weather came. Her mother asserted that there had not been the least eruption in infancy or childhood. She attended until September, and took arsenic and used ointments. She was then much better, but not nearly well.

Mary H., aged twenty-two, has been liable to a relapsing pruriginous eruption for the last ten years. It comes out badly every spring and autumn, and when it leaves her, her skin becomes perfectly sound. The eruption resembles that of Charles P., but with a more decided tendency to urticaria, having sometimes "bumps or wheals as large as half-crowns." It affected chiefly the face and arms, but sometimes occurred on the back and chest and fronts of legs. Her first attack occurred very suddenly one summer, and came out freely. She remained under care from March 15, 1870, with intervals, till April 1, 1873, during which time she took arsenic, alkalies, quinine, etc., freely, and used a great variety of local applications. She was never wholly free from the rash for more than a week or two at a time, and there was no reason to believe that the arsenic did any good. She had taken it sometimes in six-minim doses, and her own impression was that it made the skin more irritable. She was always best in cold weather, and several times during winter her rash was reduced to a few isolated spots. The last note, on April 1, 1873, records her admission for a copious outbreak which had then lasted a fortnight, and states that she had been all but well. (I have no subsequent note.)

Eliza M., married, aged thirty-eight, has suffered from relapsing prurigo for five or six years. It affected the face, arms, body, and slightly the lower extremities. She had it first the first summer of her residence in London, and she states that she always gets rid of it if she goes into the country.

The following case supplies an example of Charles P.'s prurigo beginning on the face:—

Kate N., a girl aged eleven, admitted in May, 1869, had been subject to an eruption just like Charles P.'s for eighteen months. Her face was covered with papules, many of them scratched and capped by a blood-crust. It had itched much. It had never occurred in other parts than the face, and there it avoided the eyelids and was only sparingly developed in the forehead. It affected the ears, and the parts behind them. It was usually worse in hot weather. She was in good health, and there was no history of skin disease in her relations. She attended from May to July, and took arsenic, and used lead and mercury ointment, without any benefit.

I need not, gentlemen, trouble you with more cases. Those which I have quoted must, to those who have had patience to follow me, have sufficed to illustrate most of the assertions with which I commenced. You will, I think, sympathize with me in the difficulty in finding a suitable name. Although aggravated by heat and often quite well in winter, yet it is, as we have seen, by no means an exclusively summer malady. In its broad features, however, it contrasts strongly with winter prurigo, and thus the name suggested may be found appropriate, at any rate provisionally. You will see that we want more facts, that is, more completed cases—such cases, for instance, as that of Charles P.—extending over many years, and giving the final result. When these are collected, we may be able to give a more accurate description of the malady, and to find, perhaps, a better name. In the mean time we will beware of forcing our facts into any artificial uniformity. No two cases are exactly alike, and for the obvious reason that in all mixed causes are at work.—*Med. Times and Gaz.*, February 16, 1878.

HOSPITAL NOTES AND GLEANINGS.

Menstrual Fluid retained in the left Fallopian Tube, similating Ovarian Tumour; Abdominal Section during Acute Peritonitis.—Mr. Lawson Tait, Surgeon to the Birmingham Hospital for Women, records (*British Med. Journal*, May 11, 1878) the following interesting case:—

Miss M., aged 38, was sent to me in the beginning of 1877 by my friend Mr. Alfred Freer, of Stourbridge. In November, 1876, she had an ill-defined illness, during which she had obscure pelvic pains accompanied by fever. Previously to this illness, she had been in good health and had menstruated regularly. After it, she had severe pain during the whole period of menstruation, and she gradually increased in size until Mr. Freer discovered a pelvic tumour in February last. I found the tumour to be pear-shaped, quite movable, attached to the uterus at the left cornu, evidently unilocular, and about the size of an infant's head. I diagnosed it as a cyst of the parovarium, and advised that it should be tapped after it had increased in size sufficiently to warrant interference. She returned to me in May, with the tumour increased so as to be felt above the umbilicus. I advised her to come again in a month. She came, however, before the expiry of that period, on account of a sudden accession of serious symptoms; and when I saw her on June 20th, there could be no doubt she was suffering from peritonitis. Her pulse was 130; the temperature was 38.4 deg. C. (101.12 deg. Fahr.), and rose to 39.6 deg. C. (103.28 deg. Fahr.) in the evening; and there was excessive pain all over the abdomen, with considerable flatulent distension. I administered opium freely, and applied counter-irritation over the epigastrium.

On the morning of the 21st, she was easier, but the temperature of the pulse had not fallen. I therefore had her placed under the influence of ether by Dr. A. H. Carter, and proceeded to open the abdomen, assisted by Mr. Priestley Smith. The tissues of the abdominal walls were extremely vascular, and it was necessary to use a large number of ligatures to arrest the bleeding. The peritoneum was found to be intimately adherent to the tumour; and, as soon as the latter had been laid bare for a short distance, it became evident that it was not an ovarian tumour, but presented the red muscular appearance of the uterus. Passing the forefinger of my left hand down as deeply as I could in front of the tumour, with that of my right hand in the vagina, I made out distinctly enough that my original conception of the relations of the tumour to the uterus were perfectly correct. Under the suspicion that it might be a tubal pregnancy, I did not separate the tumour further, as I had not opened the peritoneal cavity, but cautiously opened the cyst in the middle line by means of a knife. As soon as I had reached its inner coat, I passed my small trocar in and evacuated about six quarts of thick dark-brown fluid, having the peculiar smell of menstrual fluid. After the cyst was emptied, I passed my finger through the hole made by the trocar; and to my amazement, I found that the cyst had contracted; and as I kept my finger in the cavity, I distinctly felt it contracting round and grasping my finger. Passing the finger of the other hand into the vagina, I made out that what I had opened was, beyond doubt, the left Fallopian tube, and that I must have opened it close to its fimbriated extremity. I could find no canal leading into the uterus, and did not deem it advisable to make one. I washed out the cavity freely with weak carbolic lotion, by reversing the siphon action of my trocar. The wound was closed by four deep sutures, one of which was so arranged as to fasten in a loop of wire drainage-tube; but before this was done, I acted on a hint from Mr. Priestley Smith and snipped off a piece of the cyst-wall for microscopic examination. This fragment proved to be composed of an abundance of unstripped muscular fibre, conclusively supporting the view that this singular tumour was a distended Fallopian tube. After the operation, I treated her exactly like a case of ovariotomy. Her temperature fell slowly. The wound suppurated freely, and shreds of what was undoubtedly mucous membrane came away with the discharge in large quantity. The drainage-tube was removed on the twenty-first day, and its track continued to discharge till the beginning of August. It then healed, and she is now (October 18th, 1877) in perfect health, save that she has occasional pain in the wound. She has never menstruated since the operation.

From the fortunate issue of this case much is left to speculation, but of the nature of the tumour there is no doubt. As to its origin, it seems to me that it may be accounted for by the supposition that the illness from which all her symptoms dated was a localized salpingitis, which resulted in the closure of the two ends of the tube. The peritonitis, which she undoubtedly had when I operated on her, I suggest was due to a threatening rupture of the tube, and possibly a slight escape of its contents. If this be so, it is evident that it was only the accident of my determination to act promptly which saved the patient's life.

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Fracture of the Humerus by direct Muscular Action (Throwing a Cricket-Ball), no Displacement.—The great variety of cases of fracture of long bones which may be certainly attributable to direct muscular action has induced Mr. Edward Bellamy, Surgeon to Charing-Cross Hospital, to place the following case on record (*Lancet*, May 11, 1878):—

"A short time since I was sent for into the country to see a lad fourteen years of age, who had an obscure injury to the upper arm. He was a well-made, muscular boy, fond of games, and on one occasion, when he had made a great effort in throwing a cricket-ball, he felt a sudden 'crack,' as he described, in his arm, which immediately fell useless to his side. I did not see the patient until some while after the accident happened, and from what I gathered, the fact of fracture could not have been so evident. On lifting the arm there was no bending to be noticed, and it was only by rotating the shaft of the humerus gently that I could detect that the bone was really broken. The seat of fracture lay a little below the insertion of the deltoid. If we analyze the several movements by which a ball would be set in motion by the combined action of the muscles called into play, the last act of all being a violent twist, if the ball be properly thrown, I cannot help thinking that it is possible to explain thereby an instance of the 'scraube-fractur' or screw-fracture, and which we may refer to mathematically under the condition of equilibrium in pairs or twists.

"There was slight lengthening, which was replaced by the rotation I mentioned, and which rotation both gave me crepitus and rendered the length of the humerus normal, as compared with the opposite arm.

"It is interesting to note that the fracture took place at or close to the 'deltoid" curve of the humerus, and, consequently, had it not been that the opposing surfaces of the bones were in such form of contact, as I must presume, any deviation must have been immediately recognized.

"The case is, at all events, excessively rare and suggestive."

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MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Typhoid Fever.—Dr. Alonzo Clark, Professor of Pathology and Practical Medicine in the College of Physicians and Surgeons, New York, describes the treatment of typhoid fever as follows: Active treatment of this disease has been long abandoned. It used to be the fashion to bleed, and also to produce ptyalism. I remember doctors who said with confidence that where they saw evidence of the special action of mercury in these cases, they were sure of recovery. But all that has been abandoned.

Again, there were doctors, and perhaps there are some now, who put great confidence in a purgative plan of treatment; or, perhaps more strictly, an emetico-cathartic plan. An emetic and cathartic were administered together, and the cathartic was always calomel. It was claimed by those who resorted to this plan, that in certain cases abortion of the disease has been actually produced. I doubt that. In the course of an epidemic of typhoid fever, cases of ephemeral fever occur. These terminate of themselves within a few days, and the general opinion now is that those cases which have been reported as aborted cases were really cases of ephemeral fever, or cases of themselves abortive. At all events, since "Graves fed fevers," the tendency in the profession has been to treat typhoid fever with as little medicine as possible.

I may safely say to you that a case of typhoid fever of average severity needs no medication except for the relief of certain symptoms, such as sleeplessness, perhaps a little urgency in the diarrhœa, sensation of burning upon the surface of the body, etc. There are a great many cases of typhoid fever which need no treatment whatever by way of drugs, but everything by way of management of the case. Still, it does happen in many of the cases that some one of the symptoms requires treatment. The *diarrhœa*, for example, in many cases requires restraint.

Diarrhœa does not occur in every case of typhoid fever in this country; perhaps it does not occur oftener than in two-thirds of the cases. But when it does occur, the usual remedies are serviceable here as in other forms of diarrhœa. The astringent which I have referred to so frequently is found to answer a very good purpose. It consists of—℞. Bismuth. subnit. ʒi., Morphiæ sulph. gr. i. M. et div. in chart. No. xii. One to four a day. The common astringents tr. kino and tr. catechu may be employed, and the decoction of blackberry root is sometimes very serviceable. In some cases it requires the moderately free use of opium to restrain the diarrhœa.

There is always a *cough* in typhoid fever, but as it is not important in the average case, I have not mentioned it until now. There is slight bronchial irritation, which appears early in the disease, and continues usually until the period of imperfect anæsthesia is reached, when it may cease. The material raised is commonly a glairy mucus, but in some cases the slight bronchitis becomes a catarrh, and will require treatment. It will need the treatment as bronchitis occurring under any other circumstances, except that the tonic expectorants will be most likely to do good. Perhaps one of the best that can be used is the *Co. Tr. of Benzoin*, in doses of ten drops on sugar once in three or four hours. A very good combination is the tincture of the balsam of tolu and the mistura guaiaci. ℞. Mist. guaiaci ʒj. to ℥ss., Tr. balsam tolu gtts. vj. to x. M. This can be repeated every two, three, or four hours. Sometimes the inhalation of the vapour of warm water seems to be required for one or two hours each day.

Restlessness is one of the prominent features of the disease, and that will very frequently be entirely quieted by sponging the surface of the body with warm or cold water. If the temperature is high cold water is better than warm; and in some cases a Dover's powder will be required.

The *temperature of the body* will require your attention. In many cases of typhoid fever it does not rise to a dangerous point; in a few cases it does. You will see the greater number of cases go through the entire course of the disease without the temperature at any time reaching 105° F. In a case of average severity the maximum temperature is about 104° F.; in occasional cases it reaches 106° F. or 107° F., and then you will either give quinine in pretty decided doses or use cold water for its reduction. If the patient is a young person, the cold bath is the most convenient means for reducing the temperature, and certainly the most efficacious. The temperature of the bath should be only ten degrees below the temperature of the body when the patient is first put into it. If the temperature of the body be 105° F., the patient may be placed in a bath having a temperature of 95° F.; then some of the warm water can be removed, and be replaced by cold water until the bath has been reduced to 80° F. If the patient is permitted to remain in such a bath twenty minutes, the temperature is usually reduced 1, 2, 3, 4, or even 5 degrees.

He is then removed from the bath, put back into bed, and it will be several hours, usually, before the temperature will rise as high as it was before using the bath. When it rises, another bath is to be given, and in that manner you will go on repeating the bath as often as may be necessary to keep the temperature below the point of danger.

The son of one of the professors in this college has within the present session had typhoid fever. In his case the bath was used about five times a day for several days, and always with the result of reducing the temperature, and affording great relief to the patient.

For the *hemorrhage from the bowels* there is but little that can be done, unless, in addition to absolute rest, the fluid extract of ergot be administered.

For the *perforation of the bowels*, I have some faith in the opium treatment. As I told you, I feel confident that I saved one doctor's life by the narcotizing influence of opium, and there is no objection in typhoid fever to the administration of this drug.

"Graves fed fevers," typhoid fever as well as typhus; and now we come to the two essentials in the treatment of this disease. I am in the habit of repeating the old proverb, "Stuff a cold, and starve a fever," and then add that we stuff them both now. First, then, the administration, steadily and perseveringly, of such food as can be absorbed by the stomach. We cannot talk much of digestion; the stomach is in a diseased condition, and cannot digest well, consequently everything solid in the way of food is out of the question. Most of these patients dispose of milk pretty well. For all those who can dispose of it, milk is the best food that can be used. For those who cannot use it, you will be obliged to do the best you can with beef-tea, raw egg beaten up with water, and made of such consistency that it can be taken with a spoon, and the expressed juice of beef. The beef-tea does not contain a great deal of nourishment, and when it can be used, milk is a much better article of food.

The expressed juice of beef answers very well, and can be obtained by cooking a piece of steak so as just to crust the two surfaces, and then cutting it into pieces, and squeezing the juice out with a lemon-squeezer. The broths are given rather as diluted food in the early part of the disease, when it is supposed that the patient should not take much nourishment, but as the disease advances, the food should be more and more sustaining. In cases in which the stomach fails to retain food, nutritious enemata should be employed. You will remember that the disease which produces the diarrhœa, is in the small intestine, not in the large.—*Medical Record*, April 13, 1878.

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Medical and Chirurgical Faculty of Maryland.—The eightieth annual session of this body was held in Baltimore, on April 9, 10, and 11, 1878. Dr. A. B. Arnold, of Baltimore, President, in the chair. The following officers were elected for the ensuing year. President, Samuel P. Smith, M.D., of Cumberland; Vice-Presidents, Drs. J. C. Thomas and L. McLane Tiffany, of Baltimore; Secretary, W. G. Regester, M.D., of Baltimore.

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South Carolina State Medical Association.—The twenty-eighth annual session was convened at Greensville, on the 9th of April, Dr. J. F. M. Geddings, of Charleston, President, in the chair. The following officers were elected for the ensuing year: President, Dr. S. S. Marshall, of Greensville; Vice-Presidents, Drs. F. L. Parker, of Charleston; J. P. Du Bose, of Edgefield; J. J. Horton, of Kershaw; Secretary, Dr. A. S. Hydrick, of Orangeburg. The next meeting will be held at Charleston, on the second Tuesday in April, 1879.

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Georgia Medical Association.—This Association convened at Atlanta, on the 17th of April, under the Presidency of Dr. Wm. O'Daniel, of Twiggs County. The following officers were elected for the ensuing year: President, Dr. J. T. Johnson, of Atlanta; Vice-Presidents, Drs. W. F. Holt, of Macon, and T. H. Kenan, of Milledgeville; Secretary, Dr. James B. Baird, of Atlanta.

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Florida State Medical Association.—This Association convened in Jacksonville on 10th of April. The President's chair was draped in honour of the memory of Dr. F. P. Wellford, President elect. In the absence of the Vice-Presidents, Dr. T. M. Palmer, of Monticello, was called to the chair. As a mark of respect to the memory of the late President, Dr. Wellford, the Association immediately adjourned until the afternoon. The following officers were elected for the ensuing year: President, Dr. R. D. Murray, of Key West; Vice-Presidents, Drs. A. L. Randolph, of Tallahassee, and C. W. Hersey, of Fernandina; Secretary, Dr. J. Y. Porter, of Key West.

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Alabama State Medical Association.—This Society met at Eufaula, on the 9th of April. Dr. Bryce, of Tuscaloosa, President, in the chair. The following officers were elected for the ensuing year: President, Dr. R. D. Webb, of Livingston; Vice-Presidents, Drs. T. D. Baker, of Eufaula, and K. C. Baldridge, of Huntsville; Secretary, T. A. Means, of Montgomery. The next meeting will be held in Selma, on the second Tuesday in April, 1879.

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Mississippi State Medical Association.—This Association met at Jackson, April 15, Dr. B. A. Vaughn, President, in the chair. The following officers were elected for the ensuing year: President, Dr. B. F. Kittrell, of Black Hawk; Vice-Presidents, Drs. R. G. Wharton, of Port Gibson, Hanslon, Vassar, of Carrollton, and Sale, of Aberdeen; Secretary, Dr. Wirt Johnson, of Jackson. The next meeting of the Association will be held at Aberdeen, in April, 1879.

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Texas State Medical Association.—The tenth annual session convened in San Antonio, on the 10th of April, Dr. W. D. Kelley, of Galveston, presiding. The following officers were elected for the ensuing year: President, George Cupples, M.D., of San Antonio; Vice-Presidents, Drs. J. W. White, of Waco, and W. E. Saunders, of Sherman.

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Tennessee State Medical Society.—The forty-fifth annual meeting of this Society was held at Memphis, on the 2d of April, Dr. B. W. Avent, President, in the chair. The following officers were elected for the ensuing year: President, R. F. Evans, M.D., of Shelbyville; Vice-Presidents, Drs. D. D. Saunders, of Memphis, H. J. Warmuth, of Rutherford Co., E. M. Wright, of Chattanooga; Secretary, Dr. J. B. Lindsley, of Nashville. The next meeting will be held at Nashville, on the 2d of April.

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Michigan State Medical Society.—The twelfth annual meeting of this Society was held at Lansing, May 15th and 16th, Dr. Foster Pratt, President, in the chair. The following amendment to the Constitution, offered last year, elicited earnest debate: "That no person shall be admitted to membership who practices or professes to practice in accordance with any so-called pathy or sectarian school of medicine, or who has recently graduated from a medical school whose professors teach, or assist in teaching, those who propose to graduate in or practice irregular medicine."

The object of this resolution was to exclude from membership graduates of the Michigan University, in whose medical department students of homœopathy are instructed. The amendment was defeated by a vote of 42 to 61. This ended the discussion, and the recent graduates who applied for admission and were reported upon favourably were elected.

The following officers and delegates were elected for the ensuing year: President, Dr. Edward Cox, of Battle Creek; Vice-Presidents, Drs. Whelan, of Hillsdale, J. R. Thomas, of Bay City, Banks, of Walled Lake, and Dunning, of Paw Paw; Secretary, Geo. E. Ranney, of Lansing. The Society adjourned to meet next year at Detroit.

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California State Medical Society.—The eighth annual session of this Society was held at San Jose, April 17, Dr. Washington Ayer, of San Francisco, President, in the chair. The following officers were elected for the ensuing year: President, Dr. H. S. Orme, of Los Angeles; Vice Presidents, Drs. A. W. Saxe, of Santa Clara, J. M. Briceland, of Shasta, James Simpson, of San Francisco, and G. L. Simmons, of Sacramento.

Illinois State Board of Health.—The Illinois State Board of Health has resolved that on and after July 1, 1878, it will not consider any medical school in good standing which holds two graduating courses in one year, and that it will not recognize the diplomas of any medical school which does not require of its candidates for graduation the actual attendance upon at least two full courses of lectures, with an interval of six months or more.

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Metric System of Weights and Measures.—In accordance with official orders, the medical officers of the Marine Hospital service will hereafter, for all official medical and pharmaceutical purposes, make use of the metric system. In expressing quantities by weight, the terms "gramme" and "centigramme" only will be used, and in expressing quantities by measure, the term "cubic centimetre." The metric system has already, under the Act of July 28, 1866, been adopted by this service for the purveying of medical supplies, and the weights and graduated measures, as well as the glassware hereafter furnished the medical officers, will be in accordance therewith.

FOREIGN INTELLIGENCE.

Cure of Chronic Albuminuria by Fuchsine.—M. Bouchut has been employing fuchsine at the Children's Hospital, Paris, in cases of chronic albuminuria, and appears to be well satisfied with the result of his experiments. The following observations, which we abridge, were appended to a case of albuminuria supervening on scarlatina, in a child six years old. M. Bouchut had already made some trials of fuchsine in similar cases; but, as he judiciously remarks, we must have a considerable number before we can establish the value of any remedy on a solid basis. We must bear in mind that recovery may depend on nature as well as on art. On the other hand, it should be remembered that although acute albuminuria, following scarlatina, diphtheria, or parturition, is often subdued in a few weeks, the chronic form of the complaint is very obstinate, and by some of our best authorities has been pronounced incurable. At all events, there is no remedy on which we can rely with anything approaching confidence. In the particular case now alluded to the albuminuria had succeeded scarlet fever ten months previous to the child's admission into hospital, and then became complicated by general anasarca. We have, therefore, the right to infer the existence of some serious organic disease affecting the parenchymatous tissue of the kidneys. The diminution of urea was also remarkable, yet there were no symptoms of uræmic poisoning. The improvement, besides, could hardly be attributed to the milk diet on which the patient was kept. The dose, it should be mentioned, was increased from one and a half to three grains of fuchsine daily, and the patient made a good recovery in the course of a fortnight.—*Medical Examiner*, April 25, 1878.

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Marino's Antineuralgic Injection.—Ergotine, one-fourth to one-fifth of a gramme; water or glycerine, q. s. Dissolve for a hypodermic injection. It is employed in neuralgic pains, and induces a more or less intense burning sensation, which disappears in the course of half an hour if the puncture be covered by cold wet compresses. Usually it induces neither abscess nor erysipelas. One or at most two injections relieve the pains, but in order to prevent relapses, from two to six others may be given, according to the intensity and duration of the neuralgia. In tic douloureux these injections have proved very useful, while in sciatica they have often failed.—*Union Med.*, April 18, and *Med. Times and Gaz.*, April 27, 1878.

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The Treatment of Cancer by Pressure.—M. Bouchut has recently introduced to the notice of the members of the Académie des Sciences a cuirasse of vulcanized caoutchouc, which he has used with success for the treatment of cancerous and other tumours of the breast. In this country there has been much division of opinion upon the utility of pressure in the treatment of cancer, some surgeons regarding it as harmful, or but rarely useful, others attributing to it great retardation of the rapidity of growth of the tumour, or even cure. The surgeons of Middlesex Hospital studied it systematically some years ago, and gave an unfavourable report. The theory of the plan is certainly good; a neoplasia, like a healthy tissue, is dependent upon its blood-supply for vitality and growth, and complete anæmia, causes the death of a tumour, as it does of a patch of brain-substance. It will be remembered that Mr. Haward last year related at the Clinical Society a case in point. He ligatured the left lingual artery for a recurrent epithelioma of the tongue; the tumour sloughed away, and a fortnight before the patient's death from blood-poisoning, the tongue was quite healed. In just the same way ischæmia will impair the vitality and so lessen the growth of a tumour. The difficulty is rather in the practical application of this theory. The knowledge that we now possess of the mode of growth of cancers gives us at least one important indication. If we have to deal with a neoplasia that grows at the periphery by gradual infiltration of the surrounding tissues, it is plain that, for pressure to be useful, it must be applied around the tumour rather than over it, where, by compressing and obstructing the capillaries, it would cause overfulness of those at the circumference. It is the periphery of a cancer that is its active part, and we must, therefore, produce ischæmia *around* and not *in* the tumour. In the application of the treatment this must be obtained by the careful adjustment of elastic pads of cotton-wool, and as the whole success of the plan depends upon the skill with which this is done, too much attention cannot be given to it. We cannot regard pressure as a substitute for removal of a cancer; but in the frequent cases where this is impracticable it appears to be the best substitute at present open to the surgeon. M. Bouchut's cuirasse would seem to be an improvement upon the spring pads and other appliances in use in this country.—*Lancet*, April 27, 1878.

Inflammation of the Bladder.—M. GUYON has always insisted on the propriety of distinguishing acute inflammation of the neck of the bladder from ordinary cystitis. Two cases recently observed at the Necker gave an opportunity of making some remarks on a method of treating the former affection by the direct application of nitrate of silver to the inflamed part of the bladder. For the last ten years M. Guyon has employed the nitrate in cases of this kind with very satisfactory results.

The inflammation is usually a sequence of severe gonorrhœa, but may have its immediate origin in various causes, such as violent exertion, venereal excesses, and, above all, indulgence in spirituous liquors. The principal symptoms are, as we can readily understand, chiefly connected with micturition. The patient is tormented by a constant desire to make water, and the last efforts to empty the bladder are attended by an extreme degree of vesical tenesmus; in severe cases a few drops of urine only come away at a time, and the fluid is usually tinged with blood, especially during the passage of the last drops. On examining the urine in the ordinary test-glass, we find a muco-purulent deposit at the bottom of the glass, and above this deposit a thin reddish-coloured web. In severe cases, however, the blood appears to be mixed with the whole contents of the glass, and the red web, now found at the bottom of the tube, is very clearly distinguished. The treatment of inflammation of the neck of the bladder hitherto employed differs little from that of acute cystitis, and is tedious. M. Guyon has replaced it by the application of a strong solution of lunar caustic immediately to the neck of the bladder. The instrument employed for this purpose is a syringe resembling that of Pravaz, and bearing a gum-elastic tube which terminates in a bulb. The latter must be of sufficient size to be felt in the regions of the scrotum and perineum. The tactile indications thus obtained are as distinct as if they were obtained from immediate applications of the finger. In the membranous portion of the urethra the olivary bulb is moderately compressed;

in the prostatic region the pressure is somewhat increased; while entrance into the bladder is at once indicated by its freedom of motion. But to insure the certainty of this latter indication a good-sized bulb is required, otherwise the injection may be made *in* the bladder, and *not in* its neck,—an error which has occurred on some occasions. Having arrived at the neck of the bladder the surgeon employs gentle pressure on the extremity of the syringe, each stroke of which is attended by the instillation of a drop or two of its contents. The fluid excites very little pain in this portion of the urethra, and may be applied to the extent of twenty to thirty drops at a time. M. Guyon insists on the necessity of proceeding slowly, and with great care, otherwise we may bring on spasm in the membranous portion of the urethra and immediate expulsion of the injection. In nearly all cases the patient experiences some uneasiness or even pain for an hour or two after the instillation; this, however, is confined to the moment of evacuating the bladder, and in a few days the injection ceases to excite any pain worth speaking of; micturition is now less frequent, and the urine passed is free from blood.

The duration of treatment by this method is stated to be comparatively short, seldom exceeding more than seven or eight days. The solution employed by M. Guyon contains one grain of nitrate of silver to fifty parts of water.—*Medical Examiner*, May 9, 1878.

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Ointment in Gonorrhœal Orchitis.—Dr. Alvaréz recommends (*Union Méd.*, April 16) the following pomade: Finely powdered iodoform, one to two parts; lard, thirty parts. In the course of an hour or two, he says, the pain is relieved. It has also the advantage over the mercurial ointment of not affecting the gums. By its well-known resolvent action the iodoform diminishes the duration of the orchitis, and prevents subsequent induration of the affected organ. It must be used more or less strong, according to the degree of inflammation of the epididymis existing.—*Med. Times and Gaz.*, April 27, 1878.

Prevention of Puerperal Fever.—The sanitary authorities of the Tyrol have recently published a regulation to the following effect with regard to the prevention of puerperal fever. After declaring that the disease in question is of an infectious nature, and may be conveyed from one patient to another by means of instruments, sponges, or the hands of the attendant, the regulation enjoins that all instruments which have been used, even for a healthy patient, before, during, or after delivery, shall be afterwards thoroughly washed in a solution of carbolic acid. Before examining a patient, the midwife is also to take the same precaution with regard to her hands. In order that the disinfectant shall always be forthcoming, every midwife must, under a penalty, when called to a lying-in woman, take with her a concentrated (five per cent.) solution of carbolic acid. When required for use, one part of this solution is to be mixed with four parts of water.—*Medical Examiner*, April 25, 1878.

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Arterial Degeneration and Vegetable Diet.—Prof. Gubler, in his recent researches as to the causes of cretaceous degeneration of the arteries, has made the very interesting discovery that a principal cause lies in a vegetable diet, and thus explains the frequency of cretaceous arteries among the French rural population at the early age of forty. This is the more important because it is well understood that "a man is as old as his arteries," and that chalky degeneration of the arteries is the most fatal kind of premature senility. Further proof he finds in the fact that the Trappists, who live exclusively on vegetable food, very soon show arterial degeneration. In districts where chalky soils load the drinking-water with earthy salts, a vegetable diet acts more rapidly in affecting the arteries than in regions of siliceous formation.—*British Med. Journal*, April 27, 1878.

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Sewer-Communications and Filth-Diseases.—Dr. James B. Russell, the Medical Officer of Health for Glasgow, in a paper recently read before the Philosophical Society of Glasgow, has made a valuable contribution to our knowledge of the effect of sewer-gas upon the production of enteric fever and diphtheria, two of the most clearly defined filth-diseases. It appears that, since 1873, every fatal case of any zymotic disease or of lung-disease in Glasgow has been entered on a card, upon which has also been recorded, after inquiry, "minute details about the size of the house, the position of the water-closet if there be one, and also of the ashbox or sink." During the three-and-a-half years ending December last, 420 fatal cases of diphtheria and 833 of enteric fever have been dealt with in Glasgow on this detailed card system, and form the basis of Dr. Russell's investigation undertaken with a view to calculate the effect of sewer-communication in the production of these diseases. For this purpose, the houses in which these deaths from enteric fever and diphtheria were recorded were divided into four classes: (1) those having a water-closet inside, with or without a sink; (2) those having a sink inside, but no water-closet; (3) those having no connection whatever between their internal atmosphere and the sewers—that is, having neither water-closet nor sink; (4) and those concerning which, from the addresses not being found or other causes, the information was not obtained. The investigation, for reasons which it is here unnecessary to dwell upon, was confined, so far as it deals with the influence of sewer-gas, to houses of one and of two apartments. The total number of houses of each size in the city was obtained from the City Assessor's annual assessment-roll; and the proportion of the houses of each of the four classes above mentioned was determined from a return called for by Dr. Fergus in 1872, showing the numbers and the class of the houses having water-closets, drains, etc., in communication with the sewers. In order to ascertain the number of persons living in these houses of different sizes, Dr. Russell assumed that the average number of inmates of the houses in each class prevailing at the census in 1871 is still maintained. It may be stated that, in one way or other, the internal atmosphere of fully 33 per cent. of the one-apartment and 69 per cent. of the two-apartment houses was in communication with the sewers.

Dr. Russell set himself to answer the following questions: Does it make any difference to the inhabitants of a one- or two-apartment house, whether there is or is not a communication between the house-air and the sewers? Are the residents of these houses, or are they not, more liable to be fertilized with the germs of these two special filth-diseases? The number of houses of one apartment having an internal water-closet was too small to afford a trustworthy basis for calculation; but, among those persons living in houses of one apartment having no communication with the sewers, the death-rate per million was equal to 120 from diphtheria, and to 249 from enteric fever; whereas, among the residents of one-apartment houses containing a sink-communication with the sewer, the rate from diphtheria was equal to 253, and from enteric fever to 677, per million. So, in the houses of two apartments having "no direct means of access for the specific germs," the rate from diphtheria was 127, and from enteric fever 386, per million; in those having a sink, the rates became 275 and 465; while in those having an inside water-closet in addition to the sink, the death-rate from diphtheria rose to 418, and from enteric fever to 665, per million. Thus it seems to be proved that in Glasgow, during these three years and a half, the lowest death-rates from diphtheria and enteric fever occurred in those houses of one and of two apartments having no communication with the sewers; while the highest rates were found in those houses of two apartments which were provided both with water-closets and sinks. The mortality from each of these diseases was, however, found to be still higher in houses of three apartments; but, as the proportion of this class of houses provided with sewer-communications is unknown to Dr. Russell, he was unable to deal with their statistics so completely as he did with those of one and two apartments. As, however, the proportion of internal sewer-communications rose from 33 per cent. in the houses of one apartment to 69 per cent. in houses of two apartments, it is only reasonable to assume that three and four apartment houses are still more fully provided with internal sewer-communications. Hence, probably, the still higher death-rate from these diseases, the specific germs of which conclusively appear to be distributed by sewer-gas. Dr. Russell expresses his conviction, which is fully warranted by his carefully compiled statistics, that it is the absence of the sewer-connection by sink and water-closet with the internal atmosphere of a large proportion of the one- and two-apartment houses which causes the death-rates from diphtheria and enteric fever to be lower in these than in larger houses. He further says: "If every house of each size were connected alike with the drains and sewers, then I am sure the diseases specially associated with such misplaced connections would conform to the general law of other diseases, and be at their maximum in the smallest houses."

Dr. Russell concludes his valuable paper by stating that, if we would reduce the mortality from diphtheria and enteric fever to the "lowest possible minimum," not only must all internal communications with the sewers be as far as possible abolished, but our sewers and house-drains must be ventilated on the separate system, and the use of cistern-water for dietetic purposes must be entirely discontinued. There is no reason to doubt that what Dr. Russell has proved with regard to the mortality from diphtheria and enteric fever in Glasgow is more or less true with regard to their mortality in other sewered towns. It is, however, to be feared that but few medical officers of health have provided themselves with the materials for so valuable an investigation as that which has been so carefully elaborated by the indefatigable Medical Officer of Health for Glasgow.—*British Med. Journal*, May 11, 1878.

Treatment of Wounds of the Hand.—Prof. VERNEUIL (*Gaz. des Hôp.*, March 20th), on the occasion of operating on a patient who had been admitted three months before for a crushed hand, repeated to his class an emphatic injunction which he has often delivered before. Whenever, he said, you have to treat any kind of crushed wound of the hand, take it as an absolute rule to excise nothing and to regularize nothing by means of the bistoury. In these cases the surgeon should only seek to prevent and to combat the primary accidents, leaving to Nature the care of saving all she can save. She will preserve more than the surgeon could, and will always diminish the mischief. One can hardly conceive the extent to which lacerated tissues, seemingly condemned on the first day, will resume their vitality and undergo reparation. Let Nature alone, then, and wait. At a later period, after weeks or even months, when cicatrization has taken place, then only can the surgeon interfere and regularize the wound so as to render the use of his limb more easy to the patient. After describing the procedures he would have to take in order to regularize the cicatrized wound in this case, Prof. Verneuil observed that had he been tempted to interfere on the first day, some months since, he should have removed parts which can now be made useful, while the patient has passed through the intervening time favourably by the aid first of simple and then of antiseptic dressings. He contrasted the progress of this case with that of another in which, before sending the patient to the hospital, his surgeon performed some partial amputations, which were followed by phlegmon of the forearm, arthritis, and suppuration of the carpus, etc. The case demonstrates the immense difference there exists between operations performed on the hand during the acute period of the accident, and operations executed later during a condition of absolute quietude of the region. Such cases are met with daily, and the practitioner ought to have a very clear opinion and pursue a practice rigorously determined upon, never employing the bistoury in a recent wound of the hand, and never regularizing the wound until two or three months after the accident.—*Med. Times and Gaz.*, April 6, 1878.

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NOTICE TO SUBSCRIBERS.

With the present number is completed the work which for two years has occupied the "Library Department,"—GOSSELIN'S CLINICAL LECTURES ON SURGERY, translated by DR. STIMSON. In the July number will be commenced the publication of a recent and highly important volume, issued last year in England by the New Sydenham Society.

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CLINICAL LECTURES.

ON THE TREATMENT OF SPINAL ABSCESS.

By SAMUEL W. GROSS, A.M., M.D.,
Surgeon to the Philadelphia Hospital.

Many of you will remember this little girl, whom I had before you several times during the spring months of 1877. As she has been under my personal observation ever since, and as she is a striking example of recovery from spinal abscess, I again present her with the double view of giving you an opportunity of completing your study of the case, and of affording me the occasion of explaining my views as to the proper mode of treating this most unpromising affection.

Catharine B., aged 12 years, of strumous parentage, was thrown across a stove in the spring of 1874, and was soon afterwards confined to her bed in consequence of severe pains in the lower dorsal region, which were followed by angular curvature of the spine and paralysis of the lower limbs. Upon her transfer from the Childrens' Asylum to my wards, March 16th, 1877, I found her to be greatly emaciated, paraplegic, without, however, loss of sensation, deprived of appetite and sleep, and suffering from hectic fever; and I was told by Dr. Perkins, under whose care she had been, that the temperature during the vesperal exacerbations reached 103½°. There was a decided hump in the lower dorsal region, the greatest prominence being formed by the eleventh dorsal vertebra, and a large ab-

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scess was pointing in the right loin. In searching for the cause of the constitutional disturbance, I found that a psoas abscess was discharging freely on the outside of the right thigh, about three inches below Poupart's ligament.

As I desired to bring the child before you on the following day, I did not open the abscess; but, in the event of its spontaneous evacuation, which seemed to be imminent, I directed my assistant, Dr. Van Valzah, to have her closely watched, so that he could at once apply the dressings in the manner which I shall presently describe. On my next visit, at the expiration of twenty-four hours, I found that the abscess had discharged itself, and had been dressed as I had requested, and that she had been put upon twelve drops of deodorized laudanum, which was repeated every twelve hours. Under this treatment and generous diet, at the end of two weeks, she had greatly improved; the hectic fever had ceased, and the temperature was reduced to 99°. At the close of another fortnight, Sayre's plaster jacket was applied, and, in another four weeks, she was making herself useful in the ward.

The opening of the lumbar abscess closed on the 27th of July, and the plaster dressing was discontinued on the 1st of November. For the past seven months the discharge from the psoas abscess has diminished to from one to two drachms of pus daily, and it is doubtless kept up by an imprisoned necrosed piece of the body of a vertebra, which it is, of course, impossible to reach. In other respects the child is perfectly well.

The management of abscesses dependent upon caries of the vertebræ has always engaged serious attention, since they are the most common causes of a fatal issue in angular curvature of the spine, from the constitutional disturbance which ensues upon their spontaneous or artificial evacuation. While it is true that small collections of pus, particularly those seated in the dorsal region, are occasionally absorbed, of which occurrence I have met with one example in this hospital, it is equally true, that lumbar, iliac, and psoas abscesses generally attain large dimensions, and that their tendency is not to a cure by resolution, but to death from hectic irritation, septicæmia, or pyæmia.

With the view of preventing consecutive fever, it is customary to open spinal abscesses by a valvular incision or by pneumatic aspiration, the object being to avoid the admission of air into their interior, under the idea that the reaction is due to the passage into the blood of the putrid material engendered by the contact of the air with the pus. Acting upon this theory, I was formerly in the habit of resorting to subcutaneous puncture; but the uniformly bad termination of my cases led me to abandon the practice. No better results attended the aseptic method in my hands. In a case of psoas abscess connected with disease of the last dorsal and first lumbar vertebræ, and of which I show you the specimen, the pus was evacuated under lint saturated with carbolized oil, and the free opening afterwards kept covered with carbolized paste spread upon tinfoil. The patient, a woman twenty-five years of age, rapidly succumbed. In another case of abscess presenting itself in the loin, and treated in the same manner, the result was identical. Under the old plan, in which air was excluded from the sac, hectic always set in; while, under the more modern method, nothwithstanding the employment of a powerful germicide in the two instances in which I resorted to it, a fatal systemic disturbance ensued. From the fact, then, of irritative fever occurring, whether air was admitted or not, I was led to question the accuracy of the atmospheric explanation of the dangers of opening spinal abscesses; and I now altogether discard the theory that the entrance of air is the cause of the untoward symptoms.

That putrid changes are not set up in pus by the contact of the surrounding air is strikingly shown by what is known as the open-air method of treating recent wounds, such as those made in amputation, or in the excision of morbid growths, of which you have recently had a good illustration in the case of lymphoma removed from the axilla. In empyema with pneumothorax, in which the inspired air is intimately mixed with the pus, there are no signs of septicæmia from the absorption of the mixture. So also in instances of pyothorax, after the matter has been let out by free opening, experience shows that putrid changes do not occur in the fluid that remains behind. Reasoning, then, from analogy, it is difficult for me to comprehend why the innocuous atmospheric air should be held to be the cause of the ill effects of evacuating spinal abscesses.

If the hypothesis of putrid changes in the cavity of the abscess from the admission of air be abandoned, in what manner are the evil symptoms to be explained? In the elucidation of this question, I feel convinced that we must look to acute inflammation of the sac of the abscess, induced by the loss of support of its walls, through which rapid nutritive changes ensue from diminution of the resistance of its vessels to the increased pressure of the blood, and through which the cyst itself is subjected to injury.

The sac of a spinal abscess, formed as it is of a firm membrane, known as the pyogenic membrane, and the surrounding stretched and altered tissues through which the pus has travelled in its efforts to reach the surface, differs from that of a superficial chronic abscess, in that its sides do not contract and approximate after its evacuation. As a result of the tension of its vessels, due partly to the compression exerted upon them by the accumulated pus, and partly to the infiltrated condition of its walls, its blood supply is comparatively slight, and the formation of pus is a slow process. From the very moment, however, that the circulation and nutrition of the cyst are disturbed by the withdrawal of its contents, from that moment the tension of the vessels is lost, and, as natural consequences, more blood is sent to the heretofore slightly vascular membrane, its surface becomes studded with minute granulations through the dilatation of the old capillaries and the development of new ones, and pyogenesis goes on at a greatly increased rate. So rapid, indeed, is the production of pus that a day or two suffices to cause the abscess to attain dimensions which, in its closed state, was the work of months. After several evacuations, it is, moreover, a matter of repeated observation that the pus is not only thin and somewhat putrid, but that it is more or less streaked with blood, the latter phenomenon being readily explicable by the rupture of the softened capillaries from the insult to which they have been subjected by the alternate relaxation and distension of the pyogenic membrane during the discharge or accumulation of the contents of the abscess.

In illustration of the changes which ensue in the limiting sac, I show you a water-coloured drawing of a psoas abscess that had undergone spontaneous evacuation after several subcutaneous punctures. Instead of a smooth, almost bloodless membranous cyst, you will observe that the sac is highly vascular, beset with patches of ecchymosis, and covered with a grayish-white layer of aplastic lymph, with points of greenish discoloration, and areas of fatty transformation.

The theory of inflammation of the sac of the abscess, from the injury to which it has been subjected, as the cause of the consecutive fever after its spontaneous or artificial opening, is not original with me, my attention having first been directed to it by the article on Diseases of the Spine, contributed, in 1862, by Mr. Alexander Shaw, of London, to the *System of Surgery*, edited by Mr. Holmes. Mr. Shaw does not appear, however, to have utilized the explanation as a guide to practice, since he merely advises that such abscesses be treated on general principles. Other authors hold substantially similar views, among the most recent of whom is Professor Hodgen, of St. Louis, who, in a paper on Antiseptic Surgery, contained in the *Transactions of the International Medical Congress*, Philadelphia, 1876, says that the bad symptoms consequent upon opening chronic abscesses are not due so much to the admission of air as to the rekindling of destructive inflammation in their walls. Having based the management of these cases upon the truth of the hypothesis, I am led to call your attention to it, with the hope that it may prove as efficient in your hands as it has in my own.

The essential elements of the treatment are, first, to afford rest to the sac by support of its walls; and, secondly, to tranquillize the system at large, and control morbid action by the free exhibition of anodynes.

To fulfil the first indication, after the evacuation of the pus by a free incision, whereby an outlet for any detached fragments of bone is also afforded, adhesive strips, about one inch in width, are applied over the empty abscess, in such a manner that each succeeding one shall envelop one-half the preceding one, care being taken not to embrace the entire body or limb, as the case may be. An opening having been made in the dressing, so as to admit of free drainage, a large, soft, flat, moist sponge is confined over the parts by a couple of adhesive strips and a roller, and kept wet to promote its expansion, whereby gentle, equable, and systematic compression is steadily maintained. So long as the discharge continues to be abundant, the outer coverings will require a daily change, but the adhesive plaster may be allowed to remain as long as it retains its hold, although for the first few days substitution will be necessary every forty-eight hours. As soon as the granulating process has sufficiently advanced, as indicated by the marked diminution in the quantity, and the alteration in the quality of the pus, the dressings may be discontinued.

Employed in this way, compression exerts its good effects by supporting the walls of the abscess, through which they are not only kept at rest, but the tonicity of their capillaries is maintained, whereby the pyogenic process is diminished, and the danger of hemorrhage averted. By approximating its sides, moreover, less of a cavity remains to be closed by granulations, and the healing process is much expedited.

With the view to allay nervous and vascular excitement, and thereby more effectually ensure rest to the parts and the system at large, opium should be given in full doses for the first five or six days after the evacuation of the abscess. The value of anodynes in moderating the constitutional irritation has long been insisted upon by Professor Gross, and, if I mistake not, we are indebted to him for having pointed out the importance of this class of remedies in his *System of Surgery*, which first appeared in 1859.

With regard to other measures, it need scarcely be said that they should be of a tonic and sustaining nature, and that the inflamed and disintegrated vertebræ should be relieved of the pressure and friction exerted upon them by the superimposed parts, by means calculated to extend and to prevent motion of the spinal column.

In the case of the child, there can be no reasonable doubt that if the treatment, which I have outlined, had not been instituted, a fatal issue would have been rapid from the sudden and profuse drain to which her already exhausted system would have been subjected. So hopeful, indeed, was I of a favourable result, that I intentionally omitted the internal exhibition of quinia, and relied solely upon support of the sac and sustained doses of opium to prevent untoward symptoms. Under their agency the improvement in her general condition was most marked; and the application of the plaster jacket was only delayed because her sensitiveness and want of strength would not admit of her being swung in the suspending apparatus. Under opposite circumstances, this invaluable means of fixing and relieving the disintegrated vertebræ from pressure should be resorted to at once, and an opening be made in the dressing to receive the compressing sponge, which should be confined by a roller.

For an ingenious mode of applying the dressing, I cannot do better than refer you to p. 381 of Professer Sayre's work on *Orthopedic Surgery*, where you will find the details of a case of lumbar abscess which confirm the correctness of my views as to the benefit to be derived from supporting the sac, although the distinguished author advances no theory as to the cause of the dangers of evacuating spinal abscesses.

In further illustration of this subject, I will read you the notes of the first case in which I instituted the practice that was afterwards followed in that of the little girl. As it occurred before the invention of the plaster jacket, I had to content myself with enforcing strict recumbency, and fixing the spine, so far as it was possible to do so, with the brace that the man was wearing when I first saw him. As he also made a good recovery, I am led to conclude that, however valuable complete control over the movements of the spine may be in furthering and perfecting a cure, it is not essential with the view of averting hectic or other ill consequences.

John L., a weaver, aged 30, consulted me on the 24th of September, 1868, on account of scolio-cyphosis, the upper dorsal vertebræ being curved to the left, and the sixth and seventh dorsal spines projecting at least an inch and a half beyond the surrounding level. The left lumbar region was the seat of a hemispherical fluctuating swelling, which was devoid of heat, tenderness, and discoloration, and extended from the spine to the posterior border of the external oblique muscle, measuring four by four inches and three-quarters in its vertical and transverse diameters. He was weak and emaciated, having lost nearly twenty pounds of flesh, and had been forced to abandon his occupation.

The previous history, for which and for assistance in carrying out the treatment I am indebted to my friend, Dr. James Graham, was that, eleven months before I saw him, he began to complain of pain at the seat of the curvature, which soon became constant. Three months subsequently, his attendant discovered what he supposed to be scoliosis, for the relief of which a support was worn. He continued to work on half-time for six months, suffering from occasional aggravation of the local pain, which was much increased by walking. Three months before he came to me, the left loin was the seat of throbbing paroxysmal pain, and at that time he noticed a small swelling, which had gradually increased until it attained the dimensions to which I have alluded.

Under a tonic and supporting regimen and strict recumbency, his appetite soon improved, his suffering abated, and he became comfortable.

On the 4th of April, 1869, or after the lapse of six months, it was noted that "he is again losing flesh and strength; the pain in the dorsal region is severe; the abscess has increased in size; and the skin is thinned and discoloured to the extent of a ten-cent piece towards its posterior limit." It was then discovered that he had been in the habit of sitting up in bed to take his meals, and rising to pass his excretions.

On the 18th of April, a free incision gave vent to a large amount of strumous pus; the dressings were applied in the manner already described; and he was directed to take a grain of opium every six hours, along with quinia, milk punch, and a nourishing diet. One week later the report showed that "the sponge had been changed every day, and the entire dressing every other day. The discharge is abundant; he has had no constitutional disturbance, and is perfectly comfortable."

On the 3d of May, "he is gaining strength; the appetite is improving, and the discharge is decreasing." From this time until April 8th, 1870, or nearly one year after the evacuation of the abscess, when he left the city, he maintained the recumbent posture faithfully. For several months he had experienced no pain on motion or firm pressure; the affected vertebræ appeared to be firmly consolidated; he had grown quite fat; the appetite was good; all the functions were regular, and the discharge did not amount to more than one drachm in the twenty-four hours.

Med News

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

American Medical Association.—The twenty-ninth annual meeting of the American Medical Association was held at Buffalo, June 4, 5, 6, and 7, Dr. T. G. Richardson, President, in the chair.

June 4th—The Association was called to order at 11 A. M. by the President, Dr. T. G. Richardson, of New Orleans.

Dr. Thomas F. Rochester, of Buffalo, Chairman of the Committee of Arrangements, in a short address extended a cordial welcome to the Association.

The list of delegates registered was then read.

Several charges and protests were presented and referred to the Judicial Council.

The following gentlemen were elected members by invitation: Drs. George W. Stone, U. S. Marine Hospital Service; F. Lange, of Kiel, Germany; and Edward Hutchinson, of Utica, N. Y.; and the following were elected to Permanent Membership: Drs. George J. Northrup, of Marquette, Mich.; Stanford E. Chaillé, of New Orleans; and L. G. Thacker, of Defiance.

The President then delivered his Annual Address, Prof. James P. White, of Buffalo, Vice-President, occupying the chair.

Dr. Brodie, of Detroit, presented his report as delegate from the Association to the Canadian Medical Association.

Dr. E. Seguin, of New York, presented the report of the delegation to the International Medical Congress of Geneva, "to advocate the adoption of a progressive uniformity of means of observation and record."

June 5th.—The chairman of the Committee of Arrangements presented the names of the following as members by invitation: Drs. Bray and Murphy, of Chatham, Ont.; J. E. Graham, M.D., of Toronto, Secretary of the Toronto Medical Society; Dr. T. Mack, Dr. T. Clark, of St. Catherine's; Dr. McCargo, of Caledonia, Ont.; Dr. Dunn, of Lodi, N. Y., and Dr. George Rightmire, of Jacksonville, N. Y. And the name of Dr. Wm. S. Tremaine, U. S. A., Fort Dodge, Kansas, as a permanent member.

The following report was then offered by the Judicial Council:—

The charges against Dr. J. M. Keller, presented by Dr. G. W. Lawrence, were dismissed as being unworthy of any consideration.

The charges against the Society of Grand Rapids, Mich., presented by Dr. P. J. Dwyer, are incapable and unaccompanied by witnesses and testimony whereby the Judicial Council might be able to act.

The Arkansas petitions referring to the State Medical Society were dismissed without action.

The charges against the Michigan State Society by Dr. W. W. Jones, will be reported upon by Dr. N. S. Davis, Chairman of the Judicial Council.

The charges against W. T. Barr, M.D., of Abingdon, Va., presented by Dr. Ulrich, of Chester, Pa., were dismissed by the Council.

S. N. Benham, M.D.,
Secretary.

P. S.—With reference to the communication from the State Medical Society of Arkansas, notifying the Association that the Hot Springs and Garland County Medical Society was not recognized by the State Medical Society, and protesting against the reception of any member of that Society, it is decided that under the By-Laws of this Association said Hot-Springs and Garland County Society loses its recognition with the Association from date of its severance from the State Society.

Dr. N. S. Davis, of Illinois, then read the appended report of the Judicial Council concerning the charges against the Michigan State Medical Society, referred to the Council by the Association at the Annual Meeting in June, 1877:—

The charge in this case was alleged violation of the Code of Ethics on the part of the Michigan State Medical Society, in electing as a delegate to this Association Dr. E. L. Dunster, of the University of Michigan, knowing him to be engaged in aiding and abetting the graduation of students devoted to an exclusive dogma in medicine.

After a most careful examination of the Code of Ethics, as it has appeared in the Transactions of this Association from year to year, the Judicial Council fail to find any section or paragraph in it that refers, even remotely, to the practice that constitutes the foundation of the charge under consideration. That any member of the medical profession proper should ever engage in teaching, examining, and certifying to the qualifications of students, knowing that such teachings and examinations were to aid said students in obtaining a diploma directly admitting them into a fraternity of irregular practitioners—was evidently not contemplated by the framers of our Code of Ethics; and hence they inserted no clause or section bearing upon that subject. The only provision in the Code referring to those engaged in an attempt to practise medicine in accordance with some "exclusive dogma," is in the section regulating consultations at the bedside of the sick. If the Judicial Council of this national organization should assume that the section of the Code just referred to indicated the "spirit" of those who framed and adopted it, and on that assumption apply it to matters and practices entirely foreign to those mentioned in the doctrine itself, it would not only violate all the accepted principles of judicial construction, but would establish a precedent in latitudinous construction of the Ethical Code more dangerous to the best interests of the profession than all the evils sought to be remedied in the case under consideration.

It is true that this Association has adopted at different times two resolutions having reference to the subject involved in the charge against the Michigan State Medical Society, which still stand as expressions of opinion unrepealed. But these resolutions constitute no part of the Code of Ethics; neither is obedience to them enjoined by the Constitution and By-Laws on State and Local Medical Societies as a condition of representation in this Association. Therefore, while deprecating the practice of aiding or abetting in any way the teaching and graduation of students known to be supporters of irregular and exclusive dogmas in medicine, as beneath the dignity of right-minded teachers of an honourable and liberal profession, your Judicial Council can find no clause in either the Constitution, By-Laws, or Code of Ethics, as they now exist, under which the charge against the Michigan State Society can be entertained and adjudicated.

An animated discussion followed the reading of the report, and was participated in by Drs. J. M. Toner, N. S. Davis, S. C. Busey, J. J. Woodward, Wm. Brodie, and Thomas Menees. The first named moved to refer the report back to the Judicial Council, and the same was seconded by Dr. Busey. Dr. Menees offered an amendment to the effect that the report be referred back to the Council with instructions to draft a law governing the defect complained of and embracing a penalty for the punishment of the violation of the law. Before any action could be taken, the hour for the next order of business arrived.

Prof. Henry H. Smith, of Philadelphia, Chairman of the Section of Surgery and Anatomy, then delivered his address, taking for his subject: "Certain points on the Pathology of the Bones, especially Tubercle." After alluding to the opinion of former years that the skeleton was intended to support the body, he mentioned that recently a new function had been assigned it, the bones being now regarded by many as a "focus for the origin of the white and red corpuscles of the blood and through which serious diseased matter was introduced into the general circulation."

After showing its connection with septicæmia and blood poison, he discussed the original progress of tubercles in the bones, and their influence on Pott's hip disease, both of which he thought were of tubercular origin. The Address was referred to the Publication Committee.

Dr. Frank H. Hamilton, of New York, by request, next presented the essential features of a paper prepared by Dr. E. Seguin, of New York, on "The Intervention of Physicians in Education," read by the author before the Section on State Medicine and Public Hygiene the day before.

Dr. Hamilton offered the following resolution, which was unanimously adopted:—

Resolved, That in the opinion of this Association medical men ought to have a voice in the construction and location of public school buildings; in the question as to the age at which children should be admitted, the hours of study, and the general management of these institutions; and to this end it is believed to be necessary that one or more intelligent physicians should be placed upon Boards of Education, Boards of Trustees, and upon other similar boards having the control of public education and schools.

Moses Gunn, M. D., of Ill., Vice-President, took the chair, and Dr. E. W. **Jenks**, of Mich., Chairman of the Section on Obstetrics and Diseases of Women and Children, delivered an address on "The Causes of Sudden Death of Puerperal Women." On motion it was referred to the Section on Obstetrics.

A recess of ten minutes was taken to select the Committee on Nominations, and the following were appointed:—

Arkansas, A. Linthecum; Colorado, J. F. Bancroft; Connecticut, B. H. Catlin; District of Columbia, J. M. Toner; Georgia, W. F. Westmoreland; Illinois, Moses Gunn; Indiana, Jas. F. Hibbard; Iowa, G. P. Hanawald; Kansas, C. V. Mothram; Kentucky, J. M. Bodine; Louisiana, O. P. Langeworthy; Massachusetts, C. T. Collins; Maryland, T. B Evans; Maine, S. H. Weeks; Michigan, J. R. Thomas; Minnesota, C. P. Adams; Mississippi, W. M. Compton; Missouri, J. M. Allen; New Jersey, S. Lilly; New York, J. P. Gray; New Hampshire, Dr. Adams; North Carolina, Chas. Duffee, Jr.; Ohio, J. W. Russell; Pennsylvania, A. Fricke; Rhode Island, T. C. Lawton; Tennessee, J. H. Van Deman; Virginia, J. L. Cabell; Wisconsin, W. Kempster; West Virginia, J. C. Hupp; United States Navy, Dr Duvall; United States Army, Dr. J. R. Smith.

Dr. J. R. Bronson, of Mass., offered the following preamble and resolutions:—

Whereas, By the report of the Judicial Council submitted this day, we are informed that the ethical code of this Association is imperfect in that it does not recognize by its letter a conceded violation of the spirit of our profession in its relation to irregular medicine. Therefore,

Resolved, That said Council be instructed to submit to this Association at their meeting for its consideration an amendment to the Code covering this omission.

The above was on motion referred to the Judicial Council as a Committee.

Dr. Foster Pratt, of Mich., offered a resolution in relation to the legal status of the insane, which was referred to the Section on Medical Jurisprudence.

June 6th.—Dr. Rochester, Chairman of the Committee of Arrangements, presented the following names for members by invitation:—

Dr. Lawrence D. Trowbridge, of Niagara, N. Y.; Dr. Thomas McLean, of Goderich, Ont.; Dr. W. W. Potter, of Batavia, N. Y ; Dr. D. H. Kitchen, Superintendent of New York State Inebriate Asylum at Binghamton, N. Y.; Dr. H. R. Clark, Geneva, N. Y.; J. F. Goff, Cazenovia, N. Y.

A protest to the registration of a New York State delegate was read, and referred to the Judicial Council.

The Judicial Council reported that the charges against the Iowa State Medical Society, and Scott County Medical Society, presented by Dr. P. J. Farnsworth, are dismissed, because the subject had been already adjudicated by the Council at their Detroit meeting in 1874. They also reported that in the matter of the Washtenaw County Medical Society, it was decided that the Ann Arbor Society be entitled to two delegates to the present meeting The report went over for one year.

Dr. Alfred C. Post, of New York, moved that the first two on the list from the Ann Arbor Medical Society be received as delegates, the others remaining as members by invitation. Carried.

Dr. A. N. Bell, of New York, offered the following resolution, which was laid over until next year:—

Resolved, That Section Four, on Medical Jurisprudence and Psychology, and Section Five, on State Medicine and Public Hygiene, be consolidated into one section as Section Four.

Dr. N. S. Davis, of Illinois, for the Judicial Council, presented the following report proposing an amendment in addition to the Code of Ethics, and action on the same was deferred, according to the rules, for one year:—

In obedience to the instructions of this Association, the Judicial Council, acting in the Capacity of a Committee, have unanimously instructed me to report to your honourable body the following amendment and addition to paragraph 1, article 1, of the second division of the Code of Ethics, under the general heading, "Of the duties of physicians to each other, and to the profession at large," and the special heading, "Duties for the support of Professional Character." The same, when finally adopted, to be added at the end, and to constitute a part of said Paragraph 1, of Article 1. The proposed addition is in these words: "And hence, it is considered derogatory to the interests of the public, and the honour of the profession, for any physician or teacher to aid, in any way, the medical teaching or graduation of persons knowing them to be supporters and intended practitioners of some irregular and exclusive system of medicine."

Dr. J. M. Toner, of Washington, Chairman of the Committee on Necrology, presented his annual report. It was a very voluminous document, containing sketches of seventy-five physicians who had died during the past year, and owing to its great length was not read, but referred at once to the Committee on Publication.

The Secretary reported that the Committee on Catalogue of National Library was not prepared to make a report, and asked to be continued. Granted.

Dr. A. L. Loomis, of New York, Chairman of the Section on Practical Medicine, Materia Medica and Physiology, then delivered an address, which was on motion referred to the Section on Practical Medicine.

Dr. James P. White, of Buffalo, offered the following resolution:

Resolved, That a committee of five be appointed to confer with General Meyer, upon the subject of making observations as to the existence of ozone in various localities, and take such other steps and measures in the matter as may be necessary for the success of the object.

The Committee on Nominations presented the following report:

After due consideration the Committee on Nominations respectfully report that they have nominated the following gentlemen for the various offices named, to wit:—

President.—Theophilus Parvin, M.D., of Indiana.

Vice-Presidents —A. J. Fuller, M.D., of Maine; W. F. Westmoreland, M.D., of Georgia; John Morris, M.D., of Maryland; John H. Murphy, M.D., of Minnesota.

Treasurer.—Rich'd J. Dunglison, M.D., of Pennsylvania.

Librarian —Wm. Lee, M.D., of District of Columbia.

Committee on Library. — John Eliot, M.D., of District of Columbia.

Next Place of Meeting —Atlanta, Georgia.

Time of Meeting —The first Tuesday in May, 1879.

Assistant Secretary.—Scott Todd, M.D , of Atlanta, Ga

Committee of Arrangements.—J. P. Logan, Chairman; H. V. M. Miller, G. G. Crawford, H. L. Wilson, J. F. Alexander, J. M. Johnson, Charles Pinckney, V. H. Tallioferro, J. T. Johnson, of Atlanta, Ga.

The Committee also report the following nominations for Chairmen and Secretaries of Sections for 1879:

I. *Practice of Medicine, Materia Medica and Physiology.*—Dr. Thomas F. Rochester, of Buffalo, N. Y., Chairman; W. C. Glasgow, of St. Louis, Mo., Secretary.

II. *Obstetrics and Diseases of Women and Children.*—E. S. Lewis, of New Orleans, Chairman; J. R. Chadwick, of Boston, Mass., Secretary.

III. *Surgery and Anatomy.* — Moses Gunn, M.D., of Illinois, Chairman; Dr. J. R. Weist, of Indiana, Secretary.

IV. *Medical Jurisprudence, Chemistry, and Psychology.*—Dr. Wm. M. Compton, of Mississippi, Chairman; L. M. Eastman, of Maryland, Secretary.

V. *State Medicine and Public Hygiene.*— Dr. John S. Billings, of District of Columbia, Chairman; Dr. J. T. Reeve, of Wisconsin, Secretary.

Judicial Council. — To fill a vacancy caused by death: John P. Gray, of Utica, N. Y.; in place of the seven whose terms expire at this meeting: D. A Linthicum, of Arkansas, Foster Pratt, of Michigan, A. Woodward, of Connecticut, J. M. Toner, of District of Columbia, J. H. Van Deman, of Tennessee, S. M. Benham, of Pennsylvania, R. N. Todd, of Indiana.

All of which is respectfully submitted.

J. M. Toner, *Chairman*,
John C. Hupp, *Secretary*,
of the Committee.

Prof. Davis, of Chicago, presented a majority report of the Special Committee on the recommendations contained in the annual address of President Bowditch, delivered in Chicago last year, from which the following is extracted :—

After a careful review of the whole subject, indeed by many years of careful observation in the Sections of the Association, the undersigned would recommend no change in the present by-laws and ordinances regulating the working of the Sections, except the striking out of the paragraph in section 11, of the by-laws, commencing with "Papers appropriate to the several Sections," etc., and inserting in its place the following :—

"It shall be the duty of every member of the Association who proposes to present a paper or report to any one of the Sections to either forward the paper, or a title indicative of its contents, and its length, to the Chairman of the Committee of Arrangements at least one month before the annual meeting at which the paper or report is to be read. It shall also be the duty of the President and Secretary of each Section to communicate the same information to the Chairman of the Committee of Arrangements concerning such papers and reports as may come into their possession or knowledge for their respective Sections the same length of time before the annual meeting. And the Committee of Arrangements shall determine the order of reading or presentation of all such papers, and announce the same in the form of a programme for the use of all members attending the annual meeting. Such programmes shall also contain the rules specified in the by-laws and ordinances concerning the consideration and disposal of all papers in the Sections."

All of which is respectfully submitted.

N. S. Davis,
S. D. Gross.

Dr. Bowditch, of Mass., presented the following minority report:

The undersigned still holds to the opinion that the submission to trained experts of all papers read or presented to the various Sections of the Association, would tend to make our published Transactions more interresting, and vastly to increase their scientific merits, although perchance making them less bulky.

He believes, moreover, that some other of the amendments suggested by him would ultimately be of service to the Association.

He admits the cogency of the arguments of the majority of the Committee in regard to permanent membership.

He still adheres to the idea that the time spent in discussions in regard to the by-laws in any scientific body is commonly so much time wasted, which should be spent in more congenial and appropriate work, and that no changes, even though deemed very important by a few, should be made in the organic law, if they do not meet with favor with a large majority of the body.

And, finally, in full confidence that with our present by-laws, if the Chairmen and Secretaries of the Sections and of the Committee of Arrangements will do thoroughly their respective duty, the meetings of this Association and its Transactions will annually grow better as they have done in the past, the undersigned will not oppose the report of the majority of the Committee.

Henry I. Bowditch.

The majority report was adopted unanimously.

Dr. J L. Cabell, of Virginia, Chairman of the Section on State Medicine and Public Hygiene, delivered an address on State Medicine and Public Hygiene, which was on motion referred to the Section on Hygiene.

Dr. Sayre then arose to a question of personal privilege, and a ked that the Secretary be requested to place him upon record as opposed to the resolution adopted at Detroit last year, which declared that a fracture of all long bones could not occur without shortening. Granted.

June 7th.—The President announced that the Committee on Ozone, whose appointment was ordered, would consist of Doctors N. S. Davis, of Illinois, J. S. Billings, U. S. Army, W. N. Geddings, South Carolina, J. M. Toner, District of Columbia, and S. M. Bemiss, of Louisiana.

The Committee of Arrangements reported in favour of the following named physicians becoming members by invitation: W. J. A. Case, Hamilton, Ont.; George N. Burwell, Brigham Hall, Canandaigua; George Waters, Coburg, Ont.; H. C. Hill, Lockport, N. Y.; V. E. Ellsworth, East Otto, N. Y.; A. A. Hubbel, Leon, N. Y.; John W. Whitbeck, Rochester, N. Y.

Dr. J. S. Hibbard, of Indiana, offered the following resolution:—

Resolved, That hereafter it shall be the duty of the Committee on Necrology to confine their reports to the death of medical men who have been members of this Association, and at the time of death were still in good fellowship or honourably separated from the Association. Adopted.

On motion of Dr. A. N. Bell, of N. Y., the committee appointed two years ago for the organization of State Boards of Health, was continued.

A communication from the Pennsylvania State Medical Society in reference to the Metric System, was read by the Secretary, and ordered to be placed upon the record.

A resolution was offered by Dr. Seguin, of N. Y., and adopted, asking the confirmation of Doctors Sims, Drysdale, and Seguin, as delegates to Europe for the question of Medical Uniformity, to report next year.

Dr. Davis offered the following resolution, which was adopted:—

Resolved, That the Section on Practical Medicine, and Materia Medica and Physiology, recommend the appointment by the American Medical Association of a committee of five members, to whom shall be referred so much of the recommendations in the address of the President of that Section as relates to the establishment of proper sanitariums for consumptives, and the more accurate utilizing of the various mineral waters of our country, with instructions to report at the next meeting of the Association.

The Chair announced that the Committee would consist of Doctors H. I. Bowditch, Massachusetts; A. N. Bell, of New York; J. L. Cabell, of Virginia; 4. S. E. Chaillé, of Louisiana, and Charles Dennison, of Colorado.

The President announced the appointment of the following delegates:—

To European Medical Societies—Doctors Sims, Drysdale, Seguin, Daly, Halberstadt, Levis, and W. H. Pancoast.

To the Canadian Medical Association—Doctors Brodie, Todd, E. N. Brush, and W. Clarke.

The following resolutions were reported back from Section IV., and upon the recommendation of that body adopted:—

Resolved, That the personal restraint of the insane is an essential element of the medical treatment of their disease, the use of which, as a therapeutical agency, may be justified by their insanity, just as the use of it as a police agency, for the prevention of injury to person or property, is justified by their dangerous conduct.

Resolved, That, while none question the necessity for specific statutory provision to regulate the restraints of those insane persons who are wholly or partly a public charge, we maintain that it is the duty of relatives and friends, and it is also their natural and inherent right, whether declared or understood by statute, to restrain and to care for their sick or insane relatives as a private patient, at his or their expense, in his or their home, or in a legally recognized and regulated hospital; and that the exercise, by them, of so much restraint as is essential to the proper treatment of his disease, is not a violation of his rights of personal liberty; and

That their duty and right to exercise such remedial restraint, are subject to State surveillance or legal limitation only so far as may be necessary to prevent their neglect of the duty or to punish their abuse of the right.

The following amendment offered a year ago, by Dr. S. C. Scott, of Ohio, and others, was taken from the table and adopted:—

"Add to the five existing Sections a Section for Ophthalmology, Otology, and Laryngology, which shall be known and designated as Section VI."

On motion, Dr. Hermann Knapp, of New York, was appointed Chairman of the new Section, and Dr. S. C. Scott, Secretary.

Dr. Walter Kempster, of Oshkosh, Wis., Chairman of the Section of Medical Jurisprudence, Chemistry, and Psychology, delivered an able address on "The Relation of Pathology to the so-called Motor Centres."

Dr. Richard J. Dunglison, of Philadelphia, reported as follows:—

The Treasurer has the honour to report a balance in the Treasury at the end of the fiscal year of $2446.02. This amount is much larger than would have been found there had any deduction been made to pay the Permanent Secretary an honorarium for his services for the previous year. For the first time for a number of years the Association at its last meeting omitted to pass a resolution appropriating money to this end, and the Treasurer was thus left without authority to devote the funds of the Association to such a purpose. The annual amount, whatever it might be, voted by that body to its Secretary was an honorarium and not a salary, the Association having decided in 1873, upon the adverse report of a committee appointed in 1872 to decide upon the propriety of making the office a salaried one, that "no amount of specified salary be attached to the office." Ever since that time an honorarium, not a salary, has been paid him by the Treasurer, but never without authoritative order of the Association conveyed by annual resolution.

The Treasurer is in constant receipt of applications from members for volumes of the Transactions of the Association which are entirely out of print. As some of the members are in possession of scarce volumes which they may not wish to retain, the Treasurer will cheerfully act as a medium of exchange and thus accommodate those who are anxious to complete their sets. [Here followed a financial statement showing that the receipts had been $5612.47 and the expenditures $3166.45.]

On motion, $700 was voted to the Permanent Secretary for the performance of his duties.

The Committee on Prize Essays reported that the successful essayist was Dr. John A. Wyeth, of New York.

The report of the Library Committee was read.

Dr. J. M. Keller, of Arkansas, offered the following resolution, action upon which was deferred under the rule for one year:

Resolved, That in future the Committee on Nominations shall present the name of no person for appointment or election to office or position, save on the Committees on Necrology and Climatology, unless the party nominated be in attendance on the Association at the time.

Dr. J. J. Caldwell, of Maryland, offered a resolution creating a new section upon "Neurology and Electrology." Action was deferred for one year.

Dr. Maddox, of Maryland, offered another resolution, creating a section on "Diseases of the Genito-Urinary Organs, including Dermatology and Syphilis."

The following resolutions, offered by Dr. J. M. Toner, of Washington, were unanimously adopted:—

Whereas, a short time previous to the meeting of this Association, Professor Joseph Henry, late Secretary of the Smithsonian Institute, departed this life full of years and of honours; therefore, be it

Resolved, That the American Medical Association hereby offers its tribute of respect to the name of this illustrious man, whose pure and noble life, as well as his great attainments and actual discoveries, have long since placed him at the head of the men of science in this land.

Resolved, That while we share the common grief of all his fellow-countrymen on the occasion of his death, we believe his name will be embalmed in the memory of his contemporaries and of posterity, and we hold up his example for the emulation of all lovers of the truth, now and hereafter.

Resolved, That a copy of these resolutions be transmitted to the Regents of the Smithsonian Institute and to the family of the deceased.

Dr. Davis, of Illinois, called up the following amendments, proposed by him at the meeting in 1877, and the same were adopted:—

Strike out all of third paragraph, Section VIII, "It shall be the duty of every member of this Association, who learns that any existing medical school departs from the published conditions of graduation, to report the fact at the annual meetings; and, on proof of the fact, such school shall be deprived of its representation in this body."

Strike out all of second paragraph, Section IX., "This Association recognizes as a 'regular organized' medical college one that has been represented at any meeting, and that complies with the rules and directions found in the published Transactions, vol. xiii. page 33."

A proposed amendment in reference to the election of officers was offered by Dr Hitchcock, of Michigan, and under the rules it was laid over for a year.

At this point, the President-elect, Dr. Theophilus Parvin, of Indiana, was introduced by Dr. Richardson.

Dr. Parvin made a brief address, in which he took occasion to express in eloquent terms both his thanks and sense of gratification for the honour conferred in his election.

Dr. Van Deman, of Tennessee, in a few well chosen remarks, offered the usual resolutions of thanks.

On motion, the Association adjourned to meet in Atlanta, Ga., on the first Tuesday in May, 1879.

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Pennsylvania State Medical Society.—The Medical Society of Pennsylvania met at Pittsburgh, May 29th, Dr. D. Hayes Agnew, of Philadelphia, President, in the chair.

The following resolutions, in reference to a higher standard of medical education, were adopted:—

Resolved, That every member of a county society, organized, or which may hereafter be organized, under the regulations of the Medical Society of the State of Pennsylvania, before receiving any person as a student of medicine, shall require him to enter into a contract to pursue his studies for a period of not less than three years; and it shall be the duty of his preceptor to present to him a certificate, countersigned by the secretary of the local society of which he is a member, setting forth the facts as above stated.

Resolved, That it shall be the duty of all members of the profession, holding allegiance to the Medical Society of the State of Pennsylvania, to recommend their students to attend only such medical colleges as rigidly enforce the full three years' course of study in their curriculum, and otherwise conduce to elevate the standard of graduation.

The following officers were elected for the ensuing year:—

President, Dr. James L. Stewart, of Erie. Vice-Presidents, Drs. J. T. Carpenter, of Schuylkill; William Goodell, of Philadelphia; J. V. Bean, of Lancaster; A. M. Pollock, of Pittsburgh; L. Turnbull, of Philadelphia. Secretary, I. N. Kerlin, of Delaware. The next meeting will be held at Chester, on the third Wednesday in May, 1879.

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Medical Society of the State of New Jersey.—The one hundred and twelfth annual meeting of this society was held at Spring Lake, May 28 and 29, 1878, Dr. H. R. Baldwin, of New Brunswick, President, in the chair. The following officers were elected for the ensuing year: President, Dr. John S. Cook, of Hackettstown. Vice-Presidents, Drs. A. W. Rogers, of Paterson; A. N. Dougherty, of Newark; and William Elmer, Jr., of Trenton. Secretary, William Pierson, Jr., M. D, of Orange. The next meeting will be held at Englewood.

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Illinois State Medical Society.—The twenty-eighth annual meeting was held at Springfield, May 21st and 22d, 1878, Dr. J. L. White, of Bloomington, President, in the chair. The following gentlemen were elected officers for the ensuing year: President, E. P. Cook, of Mendota. Vice-Presidents, Drs. James Whitmire, of Metamora, and George W. Jones, of Danville.

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The Medical Association of the State of Missouri.—The annual meeting of the State Medical Association was held at Sweet Springs, May 21st and 22d. The following officers were elected for the ensuing year: President, E. W. Schauffler, M.D., of Kansas City. Vice-Presidents, Drs. G. M. B. Maughs, of Saint

Louis; W. P. King, of Sedalia; W. Humphrey, of Mexico; J. M. Pelot, of Brownsville; Jacob Geiger, of Saint Joseph. Secretaries, A. J. Steele, M.D., and G. A. Moses, M.D., of Saint Louis. The next meeting will be held at Sweet Springs.

Arkansas State Medical Society.—The third annual meeting was held at Fort Smith, May 1st and 2d, 1878. The following officers were elected: President, Dr. A. A. Horner, of Phillips Co. Vice-Presidents, Drs. T. W. Hurley, of Benton; W. H. Hawkins, of Little River; J. S. Shibbley, of Logan; and Isaac Folsom, of Lonoke. Secretary, Dr. R. G. Jennings. The next meeting will be held at Little Rock, on the first Wednesday of May, 1879.

Medical Society of North Carolina.—The twenty-fifth annual meeting was held at Goldsboro, May 14th, Dr. R. L. Payne, President, in the chair. The following officers were elected for the ensuing year: President, Dr. Charles Duffy, Jr., of Newbern. Vice-Presidents, Drs. J. A. Gibson, of Concord; Willis Alston, of Littleton; James McKee, of Raleigh; and A. A. Hill, of Lexington. Secretary, Dr. J. L. Picot, of Littleton. The next meeting will be held at Greensboro, on the third Tuesday in May, 1879.

University of Pennsylvania.—Dr. HARRISON ALLEN has been elected Professor of Physiology in this institution.

FOREIGN INTELLIGENCE.

Tolerance of Chloroform.—Some patients are dangerously affected by chloroform inhalations, while in others tolerance is obtained with considerable difficulty. It may also happen that chloroform, although obviously indicated in other respects, cannot be employed, on account of severe cardiac complications. A case of this latter kind presented itself to Professor Occhini, of Naples. Lithotomy was urgently required for the extraction of a large calculus; but the patient was of very nervous temperament, enfeebled by chronic suppuration, and affected with mitral insufficiency, the pulse being irregular, intermittent, and thready. On consultation, it was decided that an operation was absolutely required, but that anæsthetics were as absolutely contra-indicated. Under these discouraging circumstances, Professor Occhini resolved on trying the preventive effect of ammoniacal inspirations on the chloroform inhalations by which they were immediately followed, the theory adopted by the Professor being that the stimulant action of the ammonia on the nervous and vascular system would counterbalance the depressing influence of the anæsthetic. Some preliminary experiments gave encouraging results; the method was then applied; a very large calculus was extracted without any disturbance of the vascular or nervous systems, and the patient made a good recovery in thirty days. Encouraged by this result, M. Occhini made several experiments on patients labouring under cardiac disease in its various stages, and thus confirmed the conclusion at which he had arrived, that the tolerance of chloroform can be insured by the preventive use of ammoniacal inhalations.—*Medical Examiner*, April 25, 1878.

Poisonous Infant Powder. — The English journals report cases of poisoning of infants by the use of poisonous violet powder. The symptoms varied from those of a rash resembling roseola to those of erysipelas. Analysis has shown the powder to be adulterated in some cases with arsenic to the extent of fifty per cent. In other cases fuller's earth, lead, etc., were found.

Deaths from Chloroform.—A case of this occurring in the dentist's chair is reported in the *British Medical Journal* for May 18, 1878; another case will be found in the number for May 25th, and two more, which occurred at the Edinburgh Royal Infirmary, in the issue of June 1st.

Death under Ether.—A coal-porter, over fifty years of age, was admitted into the London Hospital for strangulated hernia last week. He was a well-developed man, and had been the subject of inguinal hernia more than three years, but till the last week had always been able to restrain it, and had never worn a truss. He had never experienced any special inconvenience from the rupture till four days before his admission to the hospital, when he was troubled with abdominal pain, complete obstruction of the bowels, and frequent vomiting, latterly becoming fæcal. His general health had been failing in an increasing degree during the last few years, so that he had sought medical advice. When admitted to hospital, he complained much of abdominal pain, and was unable to reduce his rupture. When examined, he presented a large scrotal hernia, somewhat tense. During the examination, he began vomiting fecal matter. Taxis having been used, but the symptoms remaining unrelieved, it was considered advisable to place the man under an anæsthetic. The house-surgeon accordingly administered ether, using not more than an ounce and a half in all. The patient came under the influence of the ether rapidly, and without difficulty or adverse symptoms. The local examination was then proceeded with. The patient's respirations were perfectly regular, and his pulse good, when, about six minutes after inhalation began, a sudden spasmodic inspiratory sound was heard, as if he were choking. His tongue was immediately drawn forward with the forceps; but respiration had ceased, although his pulse continued to beat for another half-minute. Silvester's artificial respiration was employed, but no spontaneous inspiratory effort followed. During the artificial respiration, some fecal matter came up into the mouth. These efforts were continued a quarter of an hour, but proved useless. At the *post-mortem* examination, the left ventricle was found contracted; but the heart appeared healthy. The lungs were extremely congested. There was fecal staining of the œsophagus and larynx, but no such matter had been drawn into the lungs. The liver was healthy. The kidneys were slightly granular, but not congested. The portion of small intestine which had been strangulated was about twenty inches in length, extremely congested, with commencing peritonitis upon its surface. It must be remembered that in such a case as this, where strangulation had existed four days and was attended with constant vomiting and a feeble circulation, there were many circumstances predisposing to death besides the administration of ether. —*British Med. Journal*, May 18, 1878.

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The Microphone in Diagnosis. — Dr. Richardson has been experimenting during the last week with Professor Hughes, the distinguished discoverer of the microphone, or sound magnifier, in order to ascertain whether the apparatus can be applied to diagnostic purposes in auscultation of the lungs and heart. It has been assumed that an instrument which makes the steps of a fly audible at a long distance can at once render any movement in the human body acutely perceptible through the sense of hearing. This is, however, a premature assumption. By means of the microphone, Dr. Richardson has been able to detect the respiratory murmur and the sounds of the heart, but not practically better, up to this time, than with the stethoscope simply. The fact is that there is considerable difficulty in making the sounds which are heard through the stethoscope pass in the form of electrical vibrations to the ear, and until this is achieved the application of the microphone for the purpose of diagnosis is not available. Further experiments are, however, in progress, and we shall hope soon to have to record that the present difficulties are overcome. To listen to a watch or a small clock through the microphone is to listen to every part, as it were, of the inanimate mechanism, so that the smallest defects are detectable; and if the same analysis of motion can be applied to the animal mechanism, Laennec himself will find an historical rival in Professor Hughes.—*Lancet*, May 25, 1878.

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The Chair of Medicine at the College of France.—Dr. Brown-Séquard has been nominated by the faculty as the successor of Claude Bernard in the Chair of Medicine. We understand that his confirmation is assured.

BURNETT ON THE EAR—Now Ready.

THE EAR; ITS ANATOMY, PHYSIOLOGY, AND DISEASES.

A Practical Treatise for the Use of Medical Students and Practitioners. By Charles H. Burnett, M.A., M.D., Aural Surgeon to the Presbyterian Hospital, Surgeon in Charge of the Infirmary for Diseases of the Ear, Philadelphia. In one handsome octavo vol. of 615 pages, with eighty-seven illustrations; cloth, $4 50; leather, $5 50.

This is an excellent treatise, and is worthy of a place among the favorite and reliable works in every student's and practitioner's library. It presents the present aspect of Otology in a clear and comprehensive manner, is free from useless verbiage and tedious theory. In addition to the original investigations of the author, made from an extensive clinical experience, he has freely availed himself of the labors of others, and given us, in proper form, the germ of truth which his extensive knowledge of the literature of the subject and vast research has enabled him to glean. We heartily commend the work as a valuable text-book for the student, and a reliable aid to the practitioner.—*Toledo Med. and Surg. Journ.*, April, 1878.

Almost all the known diseases of the ear are described in a thorough manner, and the treatment advised is judicious. Space would fail us here to analyze the many good qualities of the book, the many new and interesting investigations which are for the first time here incorporated in a text-book, the familiarity of the author with the literature of his subject, and the judicious selection which he has made from it, both in regard to pathology and treatment. The book as a whole, we can most heartily commend as a very fair exponent of our otological knowledge, and a safe and reliable guide in practice.—*Boston Med. and Surg. Journ.*, Jan. 10, 1878.

The author of this work may be congratulated on having accomplished the task of presenting to the profession, clearly and concisely, the present aspect of otology. It is a more than ordinary pleasure to review a book in which there is so much to be commended, and so little to be criticised as in this. The course of treatment advised is, in the main, wise and judicious, and is the result of intelligent observation of the effect of such treatment.—*Chicago Med. Journ. and Examiner*, Jan. 1878.

FOTHERGILL'S HANDBOOK OF TREATMENT—Just Issued.

THE PRACTITIONER'S HANDBOOK OF TREATMENT: OR, THE PRINCIPLES OF THERAPEUTICS.

By J. Milner Fothergill, M.D., Assistant Physician to the Hospital for Diseases of the Chest, to the West London Hospital, etc. etc. In one very neat octavo volume of about 575 pages: cloth, $4.

Our friends will find this a very readable book; and that it sheds light upon every theme it touches, causing the practitioner to feel more certain of his diagnosis in difficult cases. We confidently commend the work to our readers as one worthy of careful perusal. It lights the way over obscure and difficult passes in medical practice. It is a book every practitioner needs, and would have if he knew how suggestive and helpful it would be to him.—*St. Louis Med. and Surg. Journ.*, April, 1877.

None can read it without being impressed with the immense amount of common sense which is possessed by the author, as well as natural tact in interpreting the indications of treatment. His style is clear and agreeable, and he has the faculty of expounding the fundamental principles of medicine in such a way as to give them a practical application to treatment. It is, in fact, one of the most interesting, entertaining, and instructive works of its kind that we have ever read.—*Med. Record*, March 17, 1877.

We heartily commend this book to the medical student as an honest and intelligent guide through the mazes of therapeutics, and assure the practitioner who has grown gray in the harness that he will derive pleasure and instruction from its perusal. Valuable suggestions and material for thought abound throughout.—*Bost. Med. and Surg. Journ.*, March 8, 1877.

In conclusion, we must say that it is long since we have read so attractive, practical, and valuable a work. It is one that will bear long and close acquaintance, and the more often it is read, and the closer it is studied, the more will its value be appreciated by the practitioner, and the more will the latter become of value to his patient.—*St. Louis Clinical Record*, April, 1877.

FARQUHARSON'S THERAPEUTICS—Now Ready.

A GUIDE TO THERAPEUTICS.

By Robert Farquharson, M.D., Lecturer on Medicine at St. Mary's Hospital Medical School. Edited, with Additions, by Frank Woodbury, M.D. In one neat royal 12mo. volume of over 400 pages; cloth, $2.

This work supplies a want long felt of a book of small size, containing all the essentials of materia medica, but without being burdened with botanical or pharmaceutical details. What strikes us as being exceedingly useful in the work is the plan adopted of comparing the physiological with the therapeutical action of each drug; this object is carried out by arranging them in corresponding columns, in diagrammatic form. The alphabetical arrangement of the remedies we consider as very advantageous. In every instance, where a drug is known to possess merit, it is very thoroughly considered, and its therapeutical action mapped out for the reader. We recommend this work to the profession.—*N. O. Med. and Surg. Journ.*, March, 1878.

It fits right into a place which was unoccupied. The student or recent graduate will particularly appreciate this fact. He has his mind stored with much which he finds it difficult to utilize, and he yearns for some sort of an aid to this end, and we know of no work calculated more effectively to satisfy this yearning. The arrangement of the matter is very ingenious. It is printed in two parallel columns, and in corresponding paragraphs; in one column the physiological action of the remedy is discussed and in the other its therapeutical; thus the two may be compared without being obliged to forage through the whole book, as is the case with many other works. The book contains many admirable formulæ, many of which are useful, in that they specify palatable excipients for some of our most disagreeable drugs.—*Mich. Med. News*, Feb. 25, 1878.

On account of its systematic arrangement, it will greatly assist the student in memorizing, and to the practitioner it is invaluable as a book of reference.—*Nashville Journ. of Med. and Surg.*, March, 1878.

HENRY C. LEA—Philadelphia.

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By F. PEYRE PORCHER, M.D.,
Professor of Clinical Medicine and of Materia Medica and Therapeutics in the Medical College of the State of South Carolina; Assoc. Phys. to City Hospital, Charleston.

Gentlemen: In the remarks we propose to make, it is not pretended that we are bringing forward any thing essentially new; yet we can safely say that as able a work as the recent one of Stokes on Typhoid Fever, and other writings of the highest authority, have been searched in vain for a reference to any special indications for the use of alcohol in the treatment of the coma and delirium of typhoid fevers,—which our experience teaches us to regard as imperative. Such symptoms portend great peril of life, and their successful treatment is of the first importance.

We will endeavour also, on the present occasion, to assemble several diseased conditions, however diverse they may appear to be, assign to them a single cause, and a single remedy will also be held to be mainly instrumental in their treatment. If this can be done successfully, it will greatly simplify and shorten your

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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labours. Illustrative cases will be used to prove the correctness of the views expressed, to which we ask your attention with the hope that they may not be uninstructive; and with regard to them, we also wish it could be that in every respect you would resemble the scholar in "Gil Blas," who carefully searched beneath the stone, and was rewarded by the treasure which he found there.

That we do not lay too much stress upon *anæmia of the brain* as an active cause of one violent and dangerous symptom, the following extract is introduced at the beginning, among many similar ones which might be presented. In a pamphlet on *Spinal Irritation in Children as related to true and false Arthropathies*, Dr. V. P. Gibney, of N. Y., quotes Prof. Erb's article in Ziemssen's *Cyclopædia of the Prac. of Medicine* (Vol. XI. p. 284): "It is well known that extreme anæmia, at least of certain segments of the brain, and especially as it would appear of the convulsive centre, can give rise to widely extended and violent convulsions. (This however does not occur with anæmia of the spinal cord, as is shown by Stenson's experiments). . . . The irritation is probably due to accumulation of carbonic acid, or other products of disintegration, in the tissues of the brain."

Let us proceed with our examples, in the relation of which whatever is not deemed essential, will be excluded; the subjects of some of these cases you have either seen in the Hospital wards, or they have been brought before you here.

Case 1.—A. B., a scrofulous subject with inflammation and suppuration of the knee-joint, having undergone an extensive resection by a colleague, required secondary amputation of the thigh, which was done under chloroform. The prostration was so great, and there was so much *loss of blood*, that subcutaneous injection of alcohol had to be resorted to for his recovery. On the night of the day following, from these causes, coupled with some mental excitement to which he was accidentally subjected, he was seized with wakeful delirium, accompanied by violent fits of screaming, which persisted with scarcely any interruption for twenty-four hours. As we considered that the condition depended upon nervous prostration and anæmia of the brain, he was ordered whiskey every half hour, with nourishment, which was followed by complete relief. He also had quinia and opium to arrest any threat of traumatic fever.

Case 2.—A man was brought into the Hospital in the division under our care, apparently well nourished, and with a tongue fairly good; but prostrated and completely insensible. He was unable to swallow, his skin and extremities were cold, his pulse was feeble, 120 to the minute, and it seemed that he might be suffering from the effects of a narcotic poison. Theory: cause of insensibility, anæmia—want of healthy innervation and diminution of the supply of healthy blood to the brain. He recovered under active and persistent rubbing, hot applications to the surface and extremities; but subcutaneous injections of whiskey proved to be far the most effectual means for his relief. When conscious he was able to explain that he had epileptic attacks, and recently had been exposed to great privations. The temperature the third day after recovery was 99, he continued to convalesce, and was discharged cured.

Case 3.—A young gentleman (S. B.), subject to epileptiform attacks, dyspepsia, and indigestion, with a pale and unhealthy visage, underwent great excitement and an unusual draught upon his nervous system, consequent upon an examination before a board, and of great severity. Upon leaving the room he wandered about in a semi-conscious state, and when discovered he was found to have had apparently a renewal of his epileptiform attacks, with partial unconsciousness still remaining. Upon our placing him in a recumbent position, he was immediately benefited, consciousness was partially restored; and this was instantly and fully established upon administering an alcoholic stimulant. Theory: all the symptoms resulted from impaired general health, dyspepsia, indigestion, the abuse of tobacco, and other depressing causes, impairing nutrition and the quality of the blood—thus weakening the control over his nervous and vaso-motor system. Anæmia of the brain resulted; he became a ready prey to the ill effects of the mental strain to which he was subjected; and hence the explanation of the rapid relief afforded by the remedies used.

It is essential that we should declare, with due humility, *our* theory of this and other cases; because, as you know, every man, however he may sneer at them, *has* his theory; and his practice always depends upon them, as much so

"As rhymes the rudders are of verses!"

Only, as Cullen says, "some men's theories are better than other men's." This must be due to the fact that such persons, who are generally leaders both of thought and practice in their profession, are more highly endowed intellectually, are better educated and trained in the art of reasoning, with more ample stores of experience —better equipped in a word;—and their theories, consequently, are based on wider and safer generalizations. We reach, indeed, the most hidden truths by first *theorizing towards them*—as Newton, in order to attain his renowned discoveries reasoned, in his case with transcendent powers of mind, ever towards a "preconceived point." Even the most highly gifted, however, may make many failures, by throwing out their ærial tentacles in the wrong direction. Thus advised, we must be careful to lose no opportunities for acquiring knowledge, that we may build the theories which we *must use*, on firm and comprehensive foundations. A story is told in ante-bellum times which is worth relating as apropos to the subject, and which, though it may not have sounded harshly to the profane believer of those days, our humanity must halt at the conclusions of. A gentleman, who entertained the belief that the fixing the truth or falsity of a doctrine was cheaply purchased at any price, being informed that a physician in a rural district in the endeavour to establish a favourite theory, had, as the result, lost forty negroes! he rejoined, "What are forty negroes to a *theory!*"

So also, when our speculative ideas with respect to a disease, based on just views of its anatomical, pathological, and physiological relations, are correct, and enable us to be successful in its treatment, additional light is reflected thereby upon the *nature* of the malady itself; and the profound truth of the Hippocratic maxim is realized, "*naturam* morborum *curationes* ostendunt."

The following is a good example of complete unconsciousness, explicable we think upon grounds similar to those already expressed, and relieved from a great strait by similar measures. The case was drawn out by our acting House Physician, Dr. J. R. Sparkman:

Case 4.—At your request, I submit history of patient: Wm. Burden, aged about 20 years, mulatto, of good stature and well developed, admitted to Hospital at 10.30 P. M., January 30th, 1877, presenting following symptoms: perfectly unconscious, respirations about 6 to the minute, peculiar blowing sounds from mouth, foaming at the mouth, no radial pulse, carotids feeble, cardiac pulsations indistinct, head and extremities very cold, surface of body cold and moistened by a trace of sweat, cold and clammy, pupils dilated, eyes upturned and fixed, insensible to light, unable to swallow, no involuntary discharge of feces or urine. I was unable to obtain any history of patient. He was immediately placed in bed, and friction applied to extremities with dry mustard; whiskey, ʒj, being injected hypodermically, the effect was instantaneous, eyes changed position, and carotids became stronger. At the end of half an hour radial pulse could be felt like a thread. With great difficulty succeeded in giving, *per orem*, ℥ss whiskey; at the end of two minutes gave another tablespoonful; radial pulse disappears, and eyes assumed first position. At the end of half an hour gave another spoonful of whiskey, radial pulse became apparent, and after a few minutes became much stronger. By 12 P. M., patient had taken six ounces of whiskey, assistants rubbing vigourously, consciousness now returned, and by 1 o'clock A. M., patient whispered his name.

The subsequent treatment has been bromide potass. and valerian, with stimulants.

Case 5.—A gentleman (M. P.), of good constitution, and who was strictly temperate, had undergone for a length of time much depressing mental anxiety, accompanied with entire loss of appetite, by which the nutrition, the healthy condition of the blood, and the innervation were seriously impaired. Succeeding to this, increased demands were made upon his nervous system by overwork and by special causes requiring suddenly and at once more than he was able to bear. After a night of ill rest, he was at last compelled to give in; there was a tendency to incoherency, with much nervousness, and a fear of assuming an erect posture.

Immediate relief followed a single dose of alcohol; and its repetition gradually completed the restoration, by quickening the circulation and restoring to the anæmic brain a fuller supply of the blood stimulus—which was essential to the proper co-ordination of ideas and the control of the nerves which guide and excite our muscular acts.

We have no desire to multiply cases, but the following is so conclusive with regard to the special adaptability of alcohol to the immediate relief of this special class of cases, though they be very violent ones, that we invite your attention whilst we relate it.

Case 6.—At 8½ o'clock A. M. (1878), *i. e.*, at an hour when it is unlikely that men who are temperate will be found under the influence of spirits, we were summoned to see a young man, aged 20, who had been "sky-larking" with another in the store of their employer, during a brief interval of leisure. Each got a cut on the head by "brick-bats" sportively interchanged. Our patient, a temperate man, and previously in good health, it was said, had been engaged giving friendly assistance to the comrade he had wounded, when he suddenly fell, from the effects, we may suppose, of anxiety and excitement, or from the sight of blood, to which he was unaccustomed. His own wound was a slight cut on the head, which had bled very little. He had a convulsive attack with "frothing" at the mouth. We saw him twenty minutes after; found him completely insensible; he recognized no one, and replied to no questions; his limbs were convulsed and tossed wildly about, his pupils dilated, his face pale and his extremities cold. There was no fever.

It became a question whether stimulants, which his attendants, who were persons of intelligence, feared to give, were advisable. Before receiving a mixture, which was ordered, of valerian, Hoffman's anodyne, and bromide of potash, we ventured upon two ounces of whiskey, near at hand. The return to consciousness, his recognition of those around him, and the cessation of the spasms and tossing, were almost instantaneous; and he scarcely required the written prescription when it arrived—though he needed rest and to keep the recumbent position for a few hours. He was at his work in twenty-four hours. Another case was seen, 1876, in a printer's young apprentice, quite as violent, and also relieved by similar measures.

We believe that such persons, though they may pass for being in good health, are invariably not robust; that they have suffered from the effects of some depressing or exhaustive drain upon the system whether physical or emotional: that the blood-making and nervous functions are at fault; that under any unusual excitement, or sudden additional draught upon the system, the circulation through the brain is suddenly interfered with, and develops the phenomena described. Here also the cure proves what is the true character of the disease.

If inclined to be critical you might remark: that this mode of treatment seems very simple and hardly worthy of mention—this merely giving alcohol to people with nervous and convulsive attacks. To which, reply must be made: that the question of the use or non-use of stimulants is often a very grave one, and the precise indications are often difficult and delicate. At any rate, that cases so violent and apparently dangerous, should be so promptly relieved by this special remedy is a fact which we hope may prove of as signal service to you as it has been to us.

Case 7.—In a person with typhoid fever in its later stages, the blood becomes impoverished and also poisoned; the integrity of the nervous system is seriously impaired — specially indicated by *dry tongue* and sordes,—and a tendency to coma, delirium, and wakefulness supervenes. Let the characteristics of one case suffice, as it is but the repetition of hundreds in which we have observed the symptoms and their relief. The use of stimulants given every hour or oftener, and suitable food, are indicated: to improve the nutritive functions, to stimulate and increase the circulation through the brain, to strengthen the nervous system and the weakened action of the heart. The stimulants also tend to slow the pulse—quickened for want of the regulating power which the heart finds in a healthy blood supply. Binz esteems alcohol only inferior to quinia in the possession of this power over the heart and arteries.

By thus increasing the amount of blood to the brain—though that blood be inferior in quality—(with the aid also of nourishment) more oxygen reaches the organ; and the patient is enabled to survive, until such time as the diseased glands, or the intercurrent and secondary affections —whether of the thorax, abdomen or head—have had time to return to a state of health. Hence, after a very frequent experience of its utility, we make it a rule to use stimulants, in these cases also, as *often and as long as the tongue continues dry!* This, as an outward sign, is the true indication for their use; for it is generally if not always, associated with coma and delirium—for the reasons stated. Generally, also, the application of vesicatories to the back of the neck is also required, for their revulsive and stimulating effect. There is usually no determination to, or inflammation of the brain, but only an absence of blood of proper amount and quality.

Earlier in the disease, cold applications, to the head and arms, chlorate of potash, etc., are essential to restrain the fever which consumes the blood and loads it with the products of combustion and tissue metamorphosis.

Case 8.—A gentleman, aged 40, of full habit and large frame, addicted to frequent potations, *dies noctesque*, which impair his digestive, nutritive, and nervous functions, has repeated warnings by the occurrence of epileptiform seizures. Becoming daily worse and still persisting in evil courses, he suddenly falls senseless. His face is considerably disfigured and covered with blood which also pours from his nose. Called to see him without full knowledge of the previous history, and finding him in a condition so nearly resembling apoplexy—with eyes swollen and protruded (injured by the fall), lividity of the face, insensibility and stertorous breathing—we determined to resort to an unusual course, viz., apply cold to the head and draw blood from the arm! Thus, led astray by his physical injuries and his plethoric habit, our *practice* disclosed the belief that the cause was not anæmic, but the very opposite, namely apoplexy—or the two combined—for a weakened artery may coexist with an anæmic brain. After recovering consciousness very slowly, brandy was allowed, and he was immediately able to return to his rooms near by. This gentleman died a few months after (1877). With regard to whether relations, if any, existed between the phlebotomy and the fatal termination, and a "post hoc, propter hoc" can be maintained—we can say nothing!

Many persons, white and coloured, are admitted into the Insane Department of the City Hospital, at present and for many years under our care. These suffer from the various forms of alcoholic delirium and from insanity, mania, nervous excitement, loss of consciousness, hysteria, epilepsy, etc. Some are incurable lunatics; but *many* get well, because their diseases are not organic, but remedial in their nature; being only the result of a combination of causes, physical or moral, from which they may recover in course of time under proper treatment. The most important of these are: destitution, loss of rest, exposure during and after parturition, mental and moral strain during this and other conditions of weakness, protracted anxiety, want of food, etc. These all lead to *mal nutrition* with its attendant evil consequences, viz., deficient blood supply, want of healthy innervation, with absence of the power to control and co-ordinate ideas. The nature and existence of these causes are to be considered, for they are essential for the successful management of such cases. Besides the beneficial effects of rest and quiet, and the moderate use of alcoholic stimulants and suitable food, a "quieting mixture" is employed during the stage of excitement, with admirable results as a hospital formula. This is composed of substances which we thought would be most likely to serve our purpose, as follows:

℞.—Chloral hydrate, ʒvi.
Bromide of potash, ʒx.
Tinct. Valerian, ℥ii.
Hoffman's anodyne, ℥iss.
Water, q. s. ft. oij.

M. S.—A tablespoonful three times a day, or oftener, if required.

After a time, when the stage of excitement is subdued, it is found advisable to substitute "Aitken's formula," or pills of extract of nux vomica (grs. ½), quinia (grs. ½), and Quevenne's iron (grs. 1 to 2), with milk punch, etc. It will be seen from the above, that after the stage of excitement is relieved, efforts are directed to improve the condition of the blood, that the brain may recover its functions.

We will relate, in further illustration of the same practical idea, a single example out of many: besides the delirium consequent upon the abuse of alcohol, there is a true species of *insanity* which sometimes also results from it. A gentleman has been under our care suffering apparently from an incurable attack of maniacal excitement, of such violence that he was unmanageable and preparations were being made to send him to an asylum; but we predicted that *anœmia of the brain* from defective nutrition was the cause and the explanation; and that the condition was therefore curable. Theory: the incessant use of alcohol whether it be from mental depression or excitement following domestic affliction, by its effects upon the digestive organs including the liver, simply *prevented* assimilation and nutrition. He recovered perfectly in six weeks, under the plan stated above and systematically carried out, *i. e.*, alcohol gradually withdrawn, quieting agents used, and food substituted—until such time as he regained control, through a brain *replenished with healthy blood*, of his thoughts, ideas, and actions.

Case 9.—Per contra: a gentleman (Mr. L.) aged 30, of florid complexion, sanguine temperament and well nourished, and who has had previous attacks of insanity, entered the hospital with insanity and maniacal delirium of a dangerous character. He was extremely violent at times, and he endeavoured to take his own life as well as to injure others. He is not relieved by the treatment just indicated. Upon more careful thought, we first suspect and finally discover that his mania being *periodical* is in fact a *phrenesia* dependent upon *rheumatism*—which sometimes affects the meninges of the brain. So that to the above treatment we add tartarized antimony, colchicum and guiac; and he is discharged completely restored, and remained so two years after, when we last received letters conveying material marks of his gratitude.

We need not refer to the convulsions following great losses of blood; to the prevention or relief of sea-sickness by assuming the recumbent posture; to the sickness produced by swinging or certain other modes of locomotion; to the effects of nauseant emetics, etc., to illustrate farther their dependency also upon anæmia of the brain and the want of a due supply of blood thereto; with the treatment which must necessarily ensue upon this view of their cause.

HOSPITAL NOTES AND GLEANINGS.

Unusual Distension of the Bladder simulating Ovarian Tumour.—The following interesting case was treated by Dr. Lediard at the Central London Sick Asylum, Cleveland Street.

E. McL——, aged seventy-six, charwoman, was admitted on January 23d, 1878. She had had nine children; had been healthy all her lifetime up to her climacteric, which occurred at forty-two years of age; had had swelling in the belly for two years. Her face had never swelled, but the legs had for five or six weeks, and for the past four months she had kept her bed. The abdomen had increased in size during the past year, and the patient had had cough, dyspnœa, and spitting for twelve months, and for some time there had been painful micturition, and the urine had been scanty. There had been pain in the vagina for three or four weeks, and pain in the right groin for one week. The bowels were habitually constipated.

On examination the patient was anæmic and sallow, the pupils equal, tongue moist and clean, no œdema of face. She could take food, and never vomited. The abdomen presented a large fluctuating tumour of undoubted cystic character, freely movable and painless. It extended as far as the epigastrium, was dull all over, but the percussion note across the epigastric region and in the flanks was clear (the girth was not taken). The tumour did not bulge to either side, and disappeared in the pelvis. So far the evidence inclined towards an ovarian tumour. The urine was clear, free from albumen, and there was a very small amount of œdema of the legs.

Next day, examination by the vagina disclosed at once an elastic bulging filling up the vagina from the anterior wall. A catheter was passed, and exactly 212 ounces of urine were drawn off, the abdominal tumour disappearing as the water flowed away. A full-sized male vesical sound was introduced, and reached a spot corresponding to the position of the navel, but the apex of the bladder was not touched. As the bladder emptied, blood began to pass with the urine freely The abdominal wall was now thin and flaccid, having a separation of its wall in the middle line between the navel and pubes. The edge of the liver could be grasped easily through the relaxed abdominal wall. The cervix uteri was healthy, and the sound showed the uterus of natural size and mobility. The specific gravity of urine drawn off was 1006. No albumen present in that drawn before the blood passed.

Though the patient said she felt easier, the relief did not appear to be as great as might have been expected. The nurse was told to pass a catheter twice daily. The patient now exhibited thirst, and for some days an average of 150 ounces of urine were drawn off, there being no inclination to micturate. At the beginning of February the urine drawn off measured 60 to 70 ounces daily; the bowels were inactive, requiring aperients, and iron and strychnine were given, as well as expectorants for bronchitis which existed. On the 27th of February the urine drawn off was offensive, and contained pus and ropy mucus on March 6th. The patient complained of pain in the rectum, which was found stuffed with feces. Enemata were administered, but the atonied condition of the bladder remained, and the rectum appeared healthy as far as the finger and speculum could reach. The mucous surface of the bladder was now, however, tender, and the vesical walls felt rough. The motions were not passed at all, and the rectum became as inactive as the bladder, so that, in addition to the catheter, a daily enema was used. On March 15th there was pain in the rectum, and the urine was offensive and bloody. On the 19th she said she could pass her water voluntarily, and was allowed to do so; but it was found that she never emptied the bladder, for when the nurse used the catheter she invariably drew off a quantity of urine after the patient believed the bladder was empty. The bladder was now syringed out with carbolic solution, and on March the 22d the rectum was scooped out. The urine improved somewhat by the syringing, but again became offensive, and the pain in the rectum was renewed. She had a few natural passages from the bowel, but enemata were constantly required; morphia suppositories gave little or no ease, and aperients were inoperative. On the 29th, her bronchitis becoming aggravated, she was wasted and exhausted, and died on the following day. On post-mortem examination the bladder was found to be of unusual size, and, although nearly empty, yet filled up the cavity of the pelvis entirely, The mucous membrane was of a dark purple colour, and presented well-marked chronic cystitis. The walls of the bladder were exceedingly thickened, showing coarse fasciculi resembling the bladder of a man who had suffered from chronic stricture of the urethra; the orifices of the ureters were healthy, and the urethra showed no trace of disease. The rectum was distended by a large scybalous lump which occupied the hollow of the sacrum; the mucous membrane was dusky-looking, and the fecal matter was very adherent, so that there appeared to have been an absence of mucous secretion to lubricate the motions in their passage downwards. The vagina and uterus were healthy, and the other organs presented nothing worthy of mention.

Remarks.—This patient was not paraplegic, but was up and about to within a week of her death, so that the palsied condition of the bladder, which had existed for two years, must have arisen from over-distension, and the hypertrophy of the muscular fibres followed in consequence, for there was no urethral obstruction, and the water that she passed was but the dribbling of an over-full bladder. Towards the end of the case the rectum became apparently similarly atonied, but the distension resulting from fecal accumulation evidently caused much greater uneasiness than the enormous collection of water which was found on admission. An accumulation of ten pints in the female bladder is perhaps unique. Mr. Berkeley Hill has recorded a case where twelve pints were removed from a male patient. The case above recorded is interesting also from a diagnostic point of view, showing, as it does, the importance of making a vaginal examination or passing a catheter before coming to any conclusion as to the nature of an abdominal tumour in the female.—*Lancet*, June 29, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Association of American Medical Colleges.—This Association met at Buffalo, on June 4th, Prof. J. B. Biddle, of the Jefferson Medical College, President, in the chair. Fifteen Colleges were represented.

Objections against the admission of the Howard University, D. C., to the Association, were then taken up, and after some discussion the objections were sustained, and the college refused admission by a vote of 12 to 2.

The Secretary, Dr. Leartus Connor, of the Detroit Medical College, presented a report, from which it is learned that there are twenty-five regular members and one affiliated member. Application for membership had been received from the Ohio Medical College, March 26th, and the Alabama Medical College, March 18th last. As soon as the report was issued last fall, a letter was sent to all regular Medical Colleges of the United States, asking if they conformed to the articles of confederation required of regular or affiliated members. Two Colleges, Harvard and the Medical Department of the University of Pennsylvania, replied that they regarded it unadvisable for them to join the Association.

The following resolution was then offered by Prof. Flint, of New York:

Resolved, That the Secretary of the Association be and is hereby directed to furnish, one in each year, to each and every college member and to each affiliated college, a printed list of college members and affiliated colleges, the diplomas and tickets of which are to be recognized by the college members and affiliated colleges; and also to furnish to college members and affiliated colleges a printed list of those colleges (not including irregular colleges) of the United States that are not affiliated, and that are not eligible for membership of the Association, the diplomas and tickets of which are not to be recognized by college members and affiliated colleges; and also to furnish with said list of colleges not to be recognized, the dates at which said colleges had become ineligible for membership of the Association, and after which the diplomas and tickets of said college are not to be recognized.

The resolution was referred to a committee consisting of Profs. Davis, Peck, and Dunster, who were to report at the afternoon session.

Prof. Flint also offered the following

resolution accompanied by the appended communication from the College of Physicians and Surgeons of New York, seconding the same, which according to the rules holds over until the next annual meeting:—

NEW YORK, May 28, 1878.

To the Secretary of the American Medical College Association:

SIR: I have the honour to forward to you for presentation to the Association the following amendments, and I inclose a communication from the College of Physicians and Surgeons of New York seconding the same. The amendments are proposed by the Bellevue Hospital Medical College.

Amendment to Section 5, Article V., of the "Articles of Confederation" of the "American Medical College Association:"

Instead of "five per cent. of the number of matriculants," read ten per cent. of the number of graduates.

The above amendment is proposed for the reason that in certain colleges the matriculation fee is paid but once, and old matriculants may receive a matriculation ticket without paying another fee. Also, the number of graduates always represents the actual class more accurately than the number of matriculants.

Additional Section to Article VII. of the By-Laws:—

Every college member and every affiliated college shall print each year a true list of matriculants of the college for the year and their preceptors, or the names of the colleges at which the matriculants have graduated in the cases of those matriculants who are graduates in medicine; and every such college shall also print a true list of the graduates for the year.

The object of this additional section is to provide that every college member of the Association shall have proper public means of information with regard to matriculants and their preceptors and the graduates of each colleges.

The above is respectfully presented by the Bellevue Hospital Medical College.

Your obedient servant,

A. FLINT, Jr., *Secretary.*

NEW YORK, May 20th, 1878.

To the Secretary of the American Medical College Association:

SIR: At a meeting of the Faculty of this College held on May 16th, 1878, it was

Resolved, first, that an amendment, proposed by the Bellevue Hospital Medical College, to Section 5, Article V., of the articles of confederation of the American Medical College Association, and which is as follows, viz., that matriculants "be stricken out, and the words ten per cent. of the number of graduates" be inserted in the place of them, be, and the same is hereby seconded by the College of Physicians and Surgeons (Medical Department of Columbia College) in the city of New York.

Resolved, second, that an amendment proposed by the Bellevue Hospital Medical College to Article VII., of the By-Laws of the American Medical College Association, and which consists of an additional section, to read as follows, viz.: "Every college member, and every affiliate college shall print each year a true list of matriculants of the college for the year, and the preceptors, or the names of the colleges at which the matriculants have graduated, in the cases of those matriculants who are graduates in medicine, and every such college shall also print a true list of the graduates for the year," be, and the same is hereby seconded by the College of Physicians and Surgeons (Medical Department of Columbia College) in the city of New York.

Very respectfully,

Your obedient servant,

JOHN G. CURTIS,

Secretary of the Faculty.

At twelve o'clock a recess was taken until 3 P. M.

Afternoon Session.

Professor Davis, of the committee to whom was referred the resolution offered by Prof. Flint, reported back the resolution with a slight modification, and the same was then adopted.

On motion, Profs. Davis, Flint, and Gross were appointed a Committee to consider the whole matter in relation to the classification of the Medical Colleges.

Dr. S. D. Gross, a delegate from the Jefferson Medical College of Philadelphia, offered the following preamble and resolutions:—

Whereas, it is eminently desirable that the Medical Schools of this country should adopt a uniform system of instruction, of a grade fully in accord with the requirements of the age in other branches of study, and with the practice of the Medical Institutions of Europe; and

Whereas, all the efforts to bring about such a change on the part of the American Medical Association, and of the Association of Medical Teachers, assembled at Cincinnati, in 1867, and Washington City in 1869, and of different State Medical Societies have signally failed; and

Whereas, the present time seems to be peculiarly favourable for taking strong ground upon the subject, inasmuch as it is now attracting general attention throughout the United States: therefore

Resolved, That this Association respectfully and earnestly request that the regularly organized and accredited Medical Schools of the United States hold at their earliest convenience, a meeting for the purpose of adopting some definite and final action upon a subject of such vital importance to the dignity, character, and usefulness of the profession, and the welfare of the American people.

Resolved, That in order to impart proper efficiency to this plan, each and every College be requested to send two delegates, consisting of one member of each Board of Trustees, and of one member of each Faculty, with power to act for their respective institutions.

Resolved, That the medical and secular press throughout the United States be respectfully requested to lend their aid in the dissemination and discussion of these preambles and resolutions, in order to place the whole matter of medical education prominently before the profession and the public.

Resolved, That a copy of these preambles and resolutions, signed by the President and Secretary of this Association, be transmitted to the officers of every regularly constituted Medical College in the United States, with a request to hold the contemplated meeting at Washington City, or at some other central point, on the first Wednesday in September next, or as soon thereafter as practicable.

These resolutions, together with the preambles, were, after some discussion, unanimously adopted, and the time fixed upon for the meeting is the Friday preceding the meeting of the American Medical Association at Atlanta, in May, 1879.

Prof. Flint offered a preamble and resolution in effect that the tickets and diplomas of the Nashville Medical College shall not be recognized by the Association so long as the institution gives two graduating courses a year, and accepts three years' practice in lieu of a course of lectures.

The election of officers resulted as follows:—

President—J. B. Biddle, M.D.

Vice-President—N. S. Davis, M.D.

Secretary and Treasurer—Leartus Connor, M.D.

Dartmouth Medical College offered its resignation as an active member of the Association. The matter was laid on the table for one year. The Medical College at Fort Wayne having been dissolved and a new one organized, the application of the latter to the place of the former was refused. The new organization was directed to send in its formal application as a new college.

The College of Physicians and Surgeons of Indianapolis, and the Medical Department of the University of Missouri, signified their intention of applying for membership in the Association.

The Association then adjourned.

The Association of Medical Editors.—This Association met at Buffalo, on June 3d, under the Presidency of Dr. John P. Gray, Editor of the American Journal of Insanity. Dr. Gray delivered an interesting address on the laws governing the commitment of the insane to asylums, their detention, and discharge.

American Neurological Association.—The fourth annual meeting of this society was held at New York, June 19th, 20th, and 21st. A number of interesting clinical papers were read. The following officers were elected for the ensuing year: President, Dr. F. T. Miles, of Baltimore; Vice-President, Dr. S. G. Webber, of Boston; Secretary, Dr. E. C. Seguin, of New York.

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National Laryngological Association.—In response to an invitation, a number of laryngologists met at Buffalo, on June 3d, for the purpose of forming a national association. The meeting organized itself into the National Laryngological Association and elected the following officers: President, Dr. Louis Elsberg, of New York; Vice-President, Dr. F. H. Davis, of Chicago; Secretary and Treasurer, Dr. George M. Lefferts, of New York. The first annual meeting will be held in New York on the second Tuesday of June, 1879.

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Maine Medical Association.—The 26th annual meeting of this society was held at Portland, June 11th, 12th, and 13th. Dr. T. H. Jewett, of South Berwick, President, in the chair. The following officers were elected for the ensuing year: President, M. C. Wedgewood, M.D., of Lewiston; Vice-Presidents, Drs. A. J. Billings, of Freedom, and J. A. Donovan, of Lewiston; Secretary, Charles O. Hunt, M.D., of Portland. The next meeting will be held at Portland, on the second Tuesday in June, 1879.

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New Hampshire Medical Society.—This society met at Concord, in eighty-seventh annual session, on June 18th, Dr. L. M. Knight, of Franklin, President, in the chair. The following officers were elected for the ensuing year: President, A. F. Carr, M. D., of Goffstown; Vice-President, Dr. T. J. W. Pray, of Dover; Secretary, G. P. Conn, M. D., of Concord.

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Massachusetts Medical Society.—The annual meeting of this venerable society was held at Boston on the 11th and 12th of June, William Coggswell, M.D., of Bradford, in the chair. The following officers were elected for the ensuing year: President, Dr. George H. Lyman, of Boston; Vice-President, Dr. David P. Smith, of Springfield; Secretary, Dr. Charles W. Levan, of Boston. The next meeting will be held at Boston, on the second Wednesday in June, 1879.

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Medical Department of the University of Georgetown, D. C.—We take great pleasure in announcing that the Faculty of this College "in compliance with the almost universal demand for a higher standard," has adopted a graded course extending over three years, and of seven months each, and the student will be advanced from the elementary to the higher branches of instruction only after passing a satisfactory examination.

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Obituary Record.—At Milton, Pennsylvania, May 24th, 1878, Dr. **James S. Dougal**, in the eighty-fourth year of his age, known for many years as one of the ablest physicians and surgeons in the interior of the State, and loved and respected by all who knew him.

FOREIGN INTELLIGENCE.

Tubercle. — The question of tubercle seems entering upon a new and somewhat unexpected phase; indeed, it seems to require the mental agility of a pathological acrobat to understand the series of transformation scenes to which we have been treated. As our readers are aware, since Schüppel's discovery of "giant-cell systems" in scrofulous glands, there has developed a remarkable view that "giant-cell systems" are characteristic of tubercle; this has been maintained by Hering, Buhl, and others on the Continent, and adopted by Green, Hamilton, and many pathologists here. Virchow's followers have shown that giant-cell systems are distinctive of, not tubercle, but cells undergoing caseous degeneration under any and all circumstances; but this has not been regarded. Now, certain eminent French authorities, headed by Professor Charcot, affect to maintain Laennec's views, "slightly modified." They argue thus: Tubercle is characterized by the presence of giant-cells; all caseous deposits in the lungs and glands, at certain stages, may be found to contain tubercle; therefore, all such products are tubercular; and M. Charcot thinks that the "independent existence of caseous pneumonia requires to be supported by new facts." Thaon considers all strumous inflammations tubercular, or rather that all tubercle is the expression of the strumous diathesis; and that, as giant-cell systems are found in strumous glands, tubercle is only a specific product of strumous inflammation. The question of tubercle seems to us to hinge upon this: Is it a specific growth allied to the sarcomata, or is it an inflammatory product? If it be a specific growth, it is certainly determinable in a manner unlike any other member of the class, as the experiments of a few years back showed; and recently Friedländer (Virchow's *Archiv*, November, 1876) produced giant-cells, and all by cutting the recurrent laryngeal nerves in dogs. If it be inflammatory, there is an end to all dispute. If the word tubercle could be allowed to mean no more than "papule" or "pustule," that is, a form of inflammation attacking certain structures and giving rise to certain appearances, but depending upon sometimes local and sometimes general causes, a great step would have been made towards the simplification of this much-vexed and difficult problem. At present, we feel sure that many teachers must be sorely perplexed in their endeavours to be at the same time honest to themselves, and yet to teach such views as are likely to satisfy examiners.—*Brit. Med. Journ.*, May 25, 1878.

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The Anœmic Basic Murmur.—M. CONSTANTIN PAUL considers that the anæmic murmur, heard at the base of the heart, arises in the pulmonary artery. He names it the anæmo-spasmodic murmur. Unless the heart be depressed, the murmur is heard in the second intercostal space. It is not constant, because the existence of the element of vascular spasm is necessary for its production.—*British Med. Journ.*, May 25, 1878.

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Antiseptic Osteotomy.—It will have been observed that the method of operating, especially recommended by Mr. CHIENE, Surgeon to the Royal Infirmary, Edinburgh, for deformity of the lower extremities, has already recommended itself to several surgeons. The operation, as first practised by Mr. Chiene for knock-knee, consisted in removing, with antiseptic precautions, by means of a mallet and chisel, a wedge-shaped portion of bone from the internal condyle of the femur, without in any way interfering with or opening into the knee-joint. The two cases which Mr. Chiene thus treated with surprising success were shown at the Medico-Chirurgical Society, and referred to in the *Edinburgh Med. Journal* for Sept. 1877. Since then, Dr. Macewen of Glasgow (*Lancet*, March 30, 1878), in a similar way and with equal success, removed a wedge-shaped portion of bone from the anterior surface of the femur of a girl affected with a stiff bent-knee; and only lately, Mr. Barwell has described in the *British Med. Journal* (May 18), how he was able greatly to benefit two cases of almost hopeless deformity by breaking, after almost completely dividing, the bones of the leg in one case, and both leg- and thigh-bones in the other, and then keeping them in position by means of plaster-of-Paris. By similar operations—cutting down on, and either removing a wedge shaped portion, or completely dividing the bone—much good may be done for many children. When the operation is done antiseptically, the danger is reduced to a minimum, as in the cases above referred to; and, seeing that it will seldom be necessary to open into the knee-joint, it may be hoped that those acquainted with the use of antiseptics will not hesitate to give their patients the chance of escaping from being confirmed cripples. It is but right to add that the practicability of this operation was proved by Mr. Chiene more than a year ago, so that Dr. Macewen can scarcely be justified in looking on his case as "the first of antiseptic osteotomy performed in Britain."—*British Med. Journal*, June 29, 1878.

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Ununited Fracture of the Tibia.—In a clinical lecture published in a recent number of the *Gazette des Hôpitaux*, M. Duplay alludes to the frequency of delayed and imperfect union after fracture of the upper third of the tibia. In many of these cases there is no constitutional vice to which it can be attributed, and the usual local causes of non-union are absent. It has been stated that fractures above the entrance of the nutrient artery, which is directed downwards, unite less readily than those below it on account of their relation to the blood supply of the bone. But M. Duplay points out that the upper end of the tibia is the most vascular part of the whole bone, and its nutrition may, therefore, be presumed to be in a very active condition. He regards, however, this very vascularity of the bone as the cause of the difficulty of union, as, when fractured, the great number of torn vessels pour out an unusually large quantity of blood between and around the broken ends of the bone, which coagulates, and thus impedes or altogether prevents the thorough organization and ossification of the callus. He states that in these cases he has met with distinct evidence of this extensive effusion of blood.—*Lancet*, May 18, 1878.

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Emphysema as an Aid to Operation.—Dr. Bourel Roncière (*Archives de Méd. Navale*, No. 2, 1878) describes a method of blowing air into the subcutaneous and intermuscular tissue, with the effect of dissociating and isolating the different layers and the superficial tissues, and with the object of facilitating surgical operations. It is employed at the hospital at Buenos Ayres, and is effected thus. In the vicinity of the tumour, the skin is perforated with a trocar; and to the canula is attached an air-pump. The tissues in the neighbourhood are compressed to prevent undue diffusion of the emphysema; and the air is driven in by a few strokes of the piston in quantity sufficient to distend the surrounding cellular tissue and dissociate the various layers. The enucleation of tumours and the discovery of the vessels are said to be much facilitated by the process, which is described as being free from bad results. It has been employed in a large number of important operations; strangulated hernia, removal of cervical and submaxillary and axillary adenomata, ligature of large vessels, etc.—*British Med. Journal*, May 18, 1878.

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Post-mortem Cæsarean Operations.—The *Gazette Hebdom.* (June 21) states that much excitement has arisen from the performance of the Cæsarean operation after the death of the mother in two recent cases in the department of the Loire. One of these was practised an hour after death by an innkeeper, by means of a poignard-knife, at the instigation of the priest; but the infant was dead. The other was executed by a pork-butcher, at the instance of the friends of the deceased, and a living child removed, who died shortly after. One of these operators was fined five francs, and the other fifteen francs, for the "illegal practice of medicine." In both cases a doctor had been searched for in vain. Writing on the subject of post-mortem Cæsarean operations in general, Dr. Thévenot (*Progrès Med.*, June 1) calls attention to the procedure devised as a substitute by Prof. Rizzoli some forty years ago, and since had recourse to in Italy, Belgium, and Germany, although quite ignored in France, and, he might have added, in England. It is founded on the fact that at the period when death is approaching, the process of delivery often commences and sometimes is terminated, and even when this is not the case the sphincter and orifices of the cervix undergo great relaxation, so that the hand can be slowly introduced, and the child brought away by the feet. During an epidemic of cholera in 1855, Rizzoli and his colleagues delivered women in this way without any difficulty; and in three cases of eclampsia, in which the Cæsarean operation was about to be performed, delivery was effected, and the women recovered. The woman's death need not be waited for, as delivery can be effected almost as easily some hours before. This procedure is indicated in the instance of the child as giving it many more chances of life, and of the mother as her death may be sometimes only apparent.—*Med. Times and Gazette*, June 29, 1878.

Ovariotomy Statistics.—The total number of ovariotomies performed at the Samaritan Hospital, during the two years 1876–77, was 132; of these, there were 115 recoveries and 17 deaths, giving a mortality of only 12.39 per cent.—*Brit. Med. Journ.*, May 25, 1878.

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Typhoid in Milk.—Another epidemic of typhoid fever has been traced in a manner which does not admit much room for doubt to contaminated milk, thus again proving how the most essential and wholesome article of diet may become the medium for the diffusion of deadly disease. According to a special report of the medical officer of health for the Moss Side Local Board, Manchester, no less than twenty-seven persons have recently been attacked with typhoid fever. There were, besides, five cases in the neighbouring districts of Withington and Stretford. All these cases occurred in the first three months of the current year, while during the whole of 1877 but one death from typhoid was registered. Out of the thirty-two cases, twenty-nine of the patients received their milk from the same dairy. With two exceptions the ash-pits and drains in connection with the infected houses were in good order, and among 214 neighbouring households receiving milk from another dairy, there was but one household affected, and this exceptional instance is explained by the fact that the inmates were in constant communication with one of the houses already infected. The milk dealer who has been the unwilling cause of all this mischief, derived his supply partly from his own cows and partly from a farm some miles distant. Those of his customers who drank the milk from the latter source alone suffered from typhoid, and it appears that there were two deaths from typhoid at the farm-house during the month of February last. We now come to the final connecting link, and it forcibly illustrates the urgent need of sanitary reform in rural districts. The water-supply of this farm was, as is so often the case, situated close to the ash-pits, and on analyzing the water, traces of sewage contamination were easily discerned. Under such circumstances it is not surprising that the epidemic soon spread. The water contaminated with the sewage created by typhoid patients had served to wash out the pans, and perhaps even to adulterate the milk sold by this farm, but directly this supply was discontinued the outbreak of typhoid was checked. The history of this epidemic naturally recalls the celebrated outbreak of typhoid in Marylebone, which was also traced to a similar cause. With such instances before us, it is impossible to refrain from protesting against the continued carelessness that endangers our milk supply. In how many thousand farms are the ash-pits allowed to contaminate the water-supply? How few persons realize the facility with which sewage matter will percolate through the soil till it has reached the nearest water-course, where it is taken up and consumed by ready victims of contagion.—*Lancet*, May 4, 1878.

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Epidemic of Lead-Poisoning.—M. ROUZIER-JOLY has published (*Lyon Méd.*, March 31) a very interesting account of an epidemic of lead-poisoning which has occurred in the arrondissement of Beziers, in the department of Hérault. In August, 1877, a strange form of disease was there met with, extending over twenty or thirty kilometres; and although its saturnine origin was suspected, it could not be determined for three months. It was then ascertained that it arose from the subjects of the epidemic having used the flour of a mill in which the mill-stones, having become dilapidated, were repaired by pouring melted lead into the separations of their parts. The number of persons who suffered amounted to 412, occurring in 141 families, consisting of 541 individuals, of whom 129 only escaped. Of the 412 patients thirty died.—*Med. Times and Gaz.*, May 18, 1878.

Dr. ALFORD details the particulars of a local outbreak of lead-poisoning for which he could not account, as it occurred in the same part of his district, but in houses far apart. He analyzed the water, cider, preserved fruits, etc., but without detecting any lead; but, on careful inquiry, he found that the families had one thing in common, viz., they all had their flour from the same mill. An analysis of the flour showed the presence of lead; and, on going to the mill, he ascertained that, during the miller's absence, the holes in the stones had been filled up with lead. Of course the lead was removed, and the disease gradually disappeared. Some of the cases were of a very severe form ; and it appeared, on further inquiry, that this is a practice of by no means uncommon occurrence; so that, especially in country districts, this source of lead-poisoning must not be forgotten.—*British Med. Journal,* May 18, 1878.

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Boxes on the Ear.—The blindness of the late King of Hanover was occasioned, it is understood, by an accidental, and by no means violent, blow upon the eye. Scarcely a day passes, we believe, without some schoolmaster (or schoolfellow, in natural imitation of his master) giving a lad a smart "box" upon the ear. Few persons would be bold enough to choose the eye as a part upon which it was expedient to inflict a violent blow by way of moral education, but there is apparently no end to the numbers who select an organ upon which violence is liable to be attended with much more dangerous results. For not only is deafness caused by "boxes," which rupture (as they continually do) the drum of the ear, but the inflammation of the internal cavity, which is so frequent a result, may be followed, years afterwards, perhaps, by disease of the bone, giving rise to abscess of the brain, and having a fatal termination. Medical men alone can be fully aware how fruitful a source of suffering and danger is represented by the box upon the ear. We are informed, for example, of two cases, under observation at the present moment, in which schoolboys have been the victims of such an assault. Surely, schoolmasters ought to have learned, long ere this, the danger of a mode of personal chastisement that has apparently usurped the place of others, which, if more disgusting, were not attended with an equal amount of peril.

Quiet Consulting Rooms.—A case of considerable interest to the profession came before the Master of the Rolls in the Chancery Division of the High Court of Justice on Monday, June 3. The action was brought forward by Dr. Octavius Sturges, of 85 Wimpole Street, to restrain the defendant, a confectioner carrying on business in adjoining premises, from using certain large pestles and mortars fixed in the boundary wall, the noise from which formed a nuisance and annoyance to the plaintiff. The latter in 1873 had erected a consulting-room at the back of his own house in ground previously used as a garden, and abutting on the rear of the defendant's premises; and he now complained that the noise caused by the constant use of two large pestles and mortars belonging to the defendant materially interfered with the use of the consulting-room, both for his own reading, and for the purposes of consultation with patients. The nuisance was scarcely disputed, but the defendant contended that he had acquired the prescriptive right by his having employed for more than twenty years the instruments causing the nuisance. In giving judgment the Master of the Rolls remarked that the only points seriously argued were whether by prescription, or under the "Prescription Act," the defendant had become entitled to continue the nuisance. He pointed out that until the erection of the consulting-room there had been no nuisance at all, and he considered it quite impossible to presume the grant of an easement in a case of this sort, so that there was an end of the claim by prescription. Then as to the defence under the statute, he could not consider this a case of easement enjoyed "upon, over, or from" the plaintiff's land, and therefore it did not come within the act. The defence therefore failed, and the judgment was for the plaintiff, with costs.—*Med. Times and Gaz.*, June 8, 1878.

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An International Congress of Hygiene will be held at Paris during the first two weeks in August.

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CLINICAL LECTURES.

A CLINICAL LECTURE ON A CASE OF OVARIAN TUMOUR.

By WILLIAM GOODELL, A.M., M.D.,
Professor of Clinical Gynæcology in the University of Pennsylvania.

TO-DAY I bring before you this woman, to show you how to make an examination for a suspected ovarian cyst, and how to distinguish such a cyst from other tumours and other fluid collections in the abdominal cavity. Her history is as follows:—

Eight months ago she discovered a tumour in her belly, which has steadily increased in size, until, as you can plainly see, she is much hampered by its bulk. She has come to get us to tell her what it is, and what she shall do. Now the first thing that I shall do is to pass the catheter, so as to be sure that no overdistended bladder will obscure the diagnosis. Very little urine comes away. The fear of this examination has had the same effect on her as examination-day will have on some of you. Palpation now, I find, yields a sense of fluctuation but obscured by the fat-laden wall of the abdomen, which, like that of our childhood's patron saint, shakes "like a bowlful of jelly." To muffle this fat-thrill I ask one of my assistants to lay the ulnar edge of his hand along the linea alba. The pressure of the hand will act precisely like the damper-wedge of the piano-tuner, which muffles the sound of one string while its fellow is being tuned.

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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By this means I distinctly get the wave-tap of a fluid, and am able unhesitatingly to say that there is a liquid collection in the abdominal cavity. But what kind of a fluid is it? free or encysted?

If it were free, like that of ascites, while the woman lies on her back, the intestines should float up to the surface, and the fluid should gravitate to the flanks, making them bulge. But listen, and you will see that this is not the case, for the upper surface of the tumour gives a dull sound, while from each flank I elicit a clear percussion note unchanged by any position. Now this means a confined collection of fluid, and most probably a cyst. Can it be ovarian? or is it uterine? May it not be pregnancy?

The question of pregnancy is a very serious one, because it is sometimes a most difficult one to decide. One of the best surgeons of his day drove a trocar into the shoulder of a fœtus, under the idea that he was tapping a case of simple dropsy. Now this woman is under forty and sees her monthlies regularly; in fact, she saw them last week. This does not look much like pregnancy. Yet in making a diagnosis we must never take anything for granted. It is by doing so that we get into trouble. She may be wilfully deceiving us in the hopes of having a cheap abortion induced by the examination. She may be pregnant and yet menstruate. But, if pregnant, she must from her size be eight months gone, and yet the ordinary signs of pregnancy are absent. Even her breasts are withered up, and give out no milk on being squeezed. I cannot discover any fœtal heart-sounds, or fœtal movements, or fœtal limbs, or in short any evidences of pregnancy. Yet she tells us that the tumour began in the uterine region, and not in either groin, where the ovaries lie. But the bump of topography, as well as that of punctuality, is very slenderly developed in most women, so I shall lay but little stress on this statement of hers.

Let me now examine per vaginam the womb and its annexes. Were she pregnant, the cervix should feel as soft as my lips, but it is as hard as the tip of my nose—that is to say, its hardness means an empty womb. By this examination and by the previous one, pregnancy can be so confidently excluded that I may next resort to the cautious use of the sound. It goes in readily enough and gives a measurement of nigh 2.75 inches. It shows that the womb lies behind the tumour, and also gives the important information that this organ moves freely and independently of the tumour. This means that the tumour is not continuous with the womb, nor closely attached to it.

But, since it is plainly not the pregnant womb, what kind of a cyst is it? Now I have not the time to enumerate all the kinds of cysts which may be found in the abdominal cavity. For this information you must consult your text-books. But after such an examination as I have given, one has the right to infer that this fluid tumour, being in no wise uterine, is the one most frequently met with—viz., an ovarian cyst. This diagnosis can be confirmed by an examination of the fluid or by the complete evacuation of the cyst. The microscope reveals a cell, the so-called ovarian cell, which although found elsewhere in the body, is said not to exist in large numbers in any cyst of the abdomen but the ovarian. Again in ascites, the fluid is usually straw-coloured and thin. In a cyst of the broad ligament it is as clear and limpid as spring-water. In a polycyst of the ovary the fluid is likely to be thick, dark, and turbid; while that of an oligocyst, which I suspect this to be, is thinner and generally of a lighter colour. Then again, by wholly removing the fluid, the cyst collapses more or less, and one can the more readily distinguish the various organs and therefore define the site of the tumour. But this slight operation of removing the fluid from the cyst, is by no means devoid of danger. Even when the smallest aspirator needle has been used, inflammation of the cyst may follow, which will compel the immediate resort to ovariotomy. Further, the fluid of a polycyst is always intensely acrid, sometimes so much so as to irritate even the hands of the operator, and the escape of a few drops into the cavity of the abdomen may set up a violent and rapidly fatal peritonitis. For your guidance in such matters, I must therefore lay down some important rules for tapping. If you wish simply fluid enough for a microscopic examination, remove it by means of a hypodermic syringe. Should your motive be to gain time, or to relieve the pressure symptoms, or to cause such collapse of the cyst as shall aid in the diagnosis, empty the cyst *wholly*, so that no subsequent oozing may take place, and preferably by aspiration. The aim of these rules is, the avoidance of any escape of the fluid into the peritoneal cavity, and of the ingress of air into the cyst. A third rule is to perform ovariotomy and remove the cyst whenever inflammation sets in.

As my patient has come not to have ovariotomy performed, but simply to have her disease diagnosticated and to be relieved of the bulk-symptoms, I shall wholly empty the cyst by this small aspirator-needle. This is not a very painful operation, and she has been etherized more to spare her feelings than her feeling. Since the bladder has been emptied it cannot be in the way, and that is a great comfort to know, so I shall boldly thrust this needle in the linea alba, midway between the navel and the symphysis pubis, that is to say, at a point where the structures are tendinous and most free from bloodvessels. The painful part of the operation being the penetration of the skin, choose the point where you intend to puncture and plunge in the trocar-needle rapidly, as I now do. Not long ago a medical friend, in a case of ovarian cyst which we saw together, taught me a little dodge about tapping worth knowing. He took an oblong lump of ice, wrapped a rag around one end by way of a handle, and dipped the other end into some table-salt. He then for a minute or two pressed this salted end firmly on the spot selected for the puncture. This off-hand freezing mixture so benumbed the skin, that, when I thrust in the trocar-needle, not only did the lady not wince, but she chatted and laughed throughout the operation as if nothing had happened.

The fluid is as you see somewhat syrupy and of a brownish colour. It looks very like that of an ovarian cyst, but I shall defer giving a positive diagnosis until it has been examined by the microscope. By this tapping the woman will not be cured, but simply relieved. The fluid of an ovarian cyst is sure to return, except in some very rare cases of single cysts, which have been injected with iodine. And this stands to reason, for monocysts are quite rare, and it is impossible to make the trocar-needle enter every cyst of a polycyst. I am not using a tightening binder around the belly of this woman, for as she lies on her back and the fluid is being withdrawn very slowly, there will be no danger from syncope. There is at an off-hand guess about two buckets of fluid in this cyst, and as it will take some time to withdraw it, I shall utilize the remainder of my hour by talking to you about the operation of ovariotomy, and by giving you a few hints how to perform it at the home of your patient.

During this session I have twice performed this operation in this hospital, but as it was done in a private room, few of you had the opportunity of seeing it. My reason for not operating before you in this amphitheatre, much as I wished to, is that the woman's life being the first consideration, I deemed it hazardous to expose so vulnerable a membrane as the peritoneum to the cold draughts of this room, and to an atmosphere fouled by the breath of several hundred gentlemen fresh from fever wards and dissecting rooms. It would indeed be asking too much of Providence; but perhaps when the weather becomes warmer I may venture to perform it here under the carbolized spray.

Well! the first thing in an operation of this kind is to have plenty of medical assistants—one can't very well get along without four—and both the operator and his aids must be scrupulously clean and must not have seen any case of zymotic disease that day. The woman is to be prepared by a dose of oil taken early in the morning of the day preceding that of the operation. I don't stickle for oil against other cathartics, but, as an old practitioner once said to me, "It's a very sarching remedy." That night she takes a grain of opium, and another grain on the next morning. To avoid ether-vomiting her breakfast should be light. About eleven o'clock in the morning, she is to be laid on a kitchen table well covered with blankets, with her head raised on several pillows and her feet resting on a windsor chair without a back. When she is fully under ether, an incision about three inches in length is made in the median line below the umbilicus where the bloodvessels are few in number. But after cutting through skin and fat one can't always hit the linea alba. In the majority of cases the knife goes astray into the anterior sheath of one of the recti muscles, and does not keep in the central tendinous line. The red muscular fibres pouting out of the opening will be the danger signal of having got off the track into vascular regions. So stop cutting and pass in a probe across the muscle to the right and to the left, and the nearest point of arrest will note the linea alba. Again if you suppose that you can on a grooved director, cut canonically through the different layers of tissue described and engraved with so much precision in your text-books, you are much mistaken. When making this incision, all that you need to know is, when you are approaching the peritoneum. A landmark is therefore needed to warn one when to look out for it. My landmark is the thin layer of fat lying in the subperitoneal tissue. I therefore, cut down boldly through the skin and underlying fat, somewhat gingerly through the aponeurotic structures, until I reach this layer of fat which lies next to the peritoneum. Then I know that I am "getting warm"—as the boys say. So practically I regard but the following layers, skin with its subcutaneous fat, the intermediate tendinous or muscular structures, the extra-peritoneal fat, and peritoneum.

When you reach the peritoneum don't open it until all bleeding has been stopped, using either a soft napkin, or torsion, or the ligature when needed. Then hook it up by a delicate tenaculum, make a small opening, pass in a grooved director, and slit it up for a distance of from one to one-and-a-half inches. This is what is called an exploratory incision, for by it the diagnosis is confirmed, the presence of adhesions ascertained, and the possibility of completing the operation determined. When you have decided to go on with the operation, more working room will be needed, and the peritoneal wound is then to be enlarged by scissors, using the finger as a guide to prevent injury to any chance bowel-loop that may be in the way. The size of the incision will depend upon the character of the cyst, and on the number of its adhesions. Hence it may range all the way from a length of three inches to the distance from ensiform cartilage to symphysis pubis. Adhesions binding the cyst to the abdominal wall are not of much importance. To lessen the risk of hemorrhage, they are to be sundered by the finger, whenever possible. Should the scissors be used, the band of adhesion must be snipped close to the surface of the cyst and not to that of the abdominal wall. Thus a free end is gained, which may if needful be subsequently ligated, or in which the dangling bloodvessels may the more readily constringe. If the delicate omental apron be found glued to the cyst, it should be carefully detached and turned out of the abdominal cavity on a clean napkin. If its bleeding vessels be few, each one may be tied or be twisted. But if they be many, the wounded portion of the omentum may be tied *en masse*, and the ligature cut off close to the knot. By this time you will be ready to tap the cyst, and that with a large sized siphon-trocar, so that the vent may be free and none of the acrid fluid may escape into the cavity of the abdomen. The empty cyst is next to be pulled out hand over hand through the abdominal wound. But should adhesions bind the cyst to the adjacent viscera, then matters won't go along so smoothly. Such adhesions to bladder, liver, bowels, or to other important organs present difficulties which are sometimes insurmountable. The problem here is to sever these bands of adhesion without injuring the viscera to which they are attached. Sometimes it will be needful to peel off the outer and non-secreting layers of the cyst and leave them behind.

From the sundered points of attachment more or less bleeding takes place which may prove very stubborn and embarrassing. This can usually be stopped by pressure with the sponge, or the finger, or with flannel cloths wrung out of hot water, or, as I have succeeded, at Dr. Kimball's suggestion, by temporarily stuffing a clean dry sheet into the abdominal cavity. Should these means prove unavailing, then fine carbolized silk or gut ligature may be needful, and it is astonishing how many may be applied without materially compromising the safety of the woman. The free ends are always to be cut off close to the knot.

When you have at last freed the cyst, and reached its stalk, a very important question comes up, one which has never been settled and bids fair never to be, viz., how shall the stalk be treated—shall you secure it outside of the wound by such a clamp as I show you? shall you burn it off with the actual cautery? shall you ligate it and bring the free ends of the ligature out at the lower angle of the wound? or shall you tie it and cut off the ligature close to the knot? Now I cannot possibly give you a treatise on ovariotomy within the brief compass of an hour, so I shall simply say that after a careful trial of all of these methods, and after a conscientious inquiry into the subject, I lean towards tying the stalk with fine carbolized silk, the finest compatible with safety, cutting the silk off at the knot and dropping the stump into the abdominal cavity. Now when I say silk, I mean silk, and not silver nor gut ligature. Silver being inelastic cannot bind a shrinking stalk; while the gut is a treacherous ligature and will sooner or later bring one to grief. It slips in the tying; it is liable to untie; it gives instead of shrinks, and it is too shortlived for the obliteration of large vessels. You might suppose that the distal end of the ligatured stalk would slough and expose the woman to septic absorption. But such sloughing rarely happens, and for the following reasons: The peritoneal surfaces on each side of the narrow and deep gutter made by the fine silk, will bulge over and span the gap. Adhesion then takes place between the two, and the bloodvessels which shoot over from the proximal side of the ligature, will carry life into the distal end. Or lymph exuded by the irritation of the ligature will throw a living bridge across the gutter. Or, what is the least desirable, the raw end of the stalk glues itself to any peritoneal surface with which it may come in contact. I say *least desirable*, because sometimes such an adhesion constricts the calibre of an intestine, and gives trouble.

Shall we operate under the spray? shall we use drainage? are other important questions yet moot. On these points taken separately I am not yet prepared to give a final opinion, for my mind is not yet fully made up. But taken collectively I can say, that if you use the spray no drainage will be needed. If however, adhesions are many and you operate without antiseptic precautions, means of securing some form of drainage will be prudent.

Before closing the wound, return the omentum, and very gently spread it over the intestine. Bring the lips of the wound together by silver sutures passed in on each peritoneal surface about half an inch from the edge, and through the whole thickness of the abdominal wall. You can do this by one stout needle armed with a silk loop, over which the ends of each wire are successively hooked. The object of including the peritoneum is to bring in contact two long ribband-like surfaces of serous membrane which quickly unite. After the sutures are twisted, carry two or three broad strips of adhesive plaster around the whole body, and cover the wound by a pledget of lint dipped in carbolized oil. On this should be laid a roll of cotton-wool, and over all an elastic flannel binder, the rucking of which can be prevented by tapes pinned to it around each thigh.

Until all danger from vomiting is passed, the woman's diet should be very spare, not more than sips of milk or of beef-tea, then it may be cautiously increased. The dressing need not be renewed for three or four days, and the stitches not cut until a week has elapsed.

But to return to our patient, you see

that the cyst is nearly empty, and the belly quite flat. More fluid yet remains however, but as my hour has slipped by, I shall wheel her out and finish the operation in my private room. A small piece of plaster will be placed over the puncture—I have used a postage stamp at a pinch—an obstetric binder will be pinned around her belly, and she will be kept at rest until all danger from inflammation has passed.

HOSPITAL NOTES AND GLEANINGS.

Cases of Primary and Secondary Sclerosis of the Spinal Cord.—There are now a number of cases of disease of the spinal cord in the Hospital for Epilepsy and Paralysis, Regent's Park, under the care of Dr. ALTHAUS, in which the seat and extent of the lesion have been diagnosed with a considerable degree of certainty. In one of these cases the pathological change is strictly limited to the anterior cornua of the gray matter in the lumbar enlargement of the cord, as there is motor paralysis of the lower extremities, without any affection of sensibility, but accompanied with muscular atrophy which has set in rapidly, there being complete loss of faradic excitability of the muscles and nerves, and greatly diminished galvanic or voltaic excitability of the same. There is not the slightest affection of the bladder and rectum, and no tendency to bedsores, so that an affection of the posterior cornua, and columns is excluded. The case is mending slowly under the influence of iodide of potassium, phosphorus, sulphur-baths, and galvanization of the cord. We will, however, to-day give the details of two cases only, one of which Dr. Althaus diagnosed as primary sclerosis of the external portion of the posterior columns, while the other was stated to be one of secondary sclerosis of the posterior or crossed pyramidal portion of the lateral column of the cord.

CASE 1.—*Primary Sclerosis of the External Portion of the Posterior Columns.*—J. R., forty, single, a commercial traveller, admitted January 25, 1878. He has travelled much in the tropics, undergone great exposure to cold and heat, and lived altogether a wild life, exceeding in drinking and sexual relations. Five years ago he had an attack of delirium tremens. He also had some time ago a soft chancre and gonorrhœa, which resulted in stricture of the urethra, but never had constitutional syphilis. There is no hereditary neurotic tendency. Two years ago, when in South America, he first began to feel difficulty in walking, and was some time afterwards admitted into the hospital at Buenos Ayres, where he remained three months. He noticed that he walked much worse in the dark than in the daytime, and was obliged to look at his feet when walking in order to direct their movements. Six months ago he returned to this country; and two months before admission he was still able to go about, and could at a stretch walk three or four miles. One day, however, when about to cross a street, he had to make a sudden jump in order to avoid a cab running him over. This appeared to give him a strain in the back, and from that time he has gone down steadily.

Present State.—The brain is quite free from disease, but the third left cranial nerve or motor oculi is affected, there being paralysis of the rectus internus and the obliquus inferior muscles of the left eye. The patient is therefore unable to turn that eye upwards and inwards, thus showing divergent squint: there is crossed diplopia, and the lateral distance between the double images increases as the object is carried over to the right side. At first sight there appears also to be ptosis of the left eye, as the eye is habitually covered by the lid; but on closer examination it is found the levator palpabræ superioris is not paralyzed, but has been intentionally put out of action by the patient, so as to avoid the annoyance of the diplopia; and the eye can be opened at request without any difficulty. The ocular muscles of the right eye and all the other cranial nerves are quite healthy. Vision is perfect, and the ophthalmoscope does not reveal any textural changes in the eyes. The cord affection in this case is at present confined to the lumbar enlargement. The upper extremities and the thoracic and abdominal viscera are quite healthy. Incomplete anæsthesia, however exists in the hypogastric region and the lower extremities, being more marked in the feet and legs than in the thighs and hips. On standing the patient feels the ground quite soft, like velvet or cotton; he is still able to feel the prick of a pin and touch of the fingers, but there is great numbness. Temperature and pressure are well perceived. The reflex action of the skin is normal, but tendinous reflexion is gone in the knees and feet. The power of walking is entirely gone, and the patient has great difficulty in getting up from a chair, nor can he stand except when supported on both sides; yet he can easily cross one leg over the other, and move the legs in all directions when sitting or lying down. There is malnutrition of the muscles of the lower extremities, which have become flabby and thin by disuse; yet they respond quite well to both the faradic and voltaic current, showing that there is the proper relation between them and the anterior cornua of the cord. The patient has no difficulty in passing and retaining his water; the bowels are habitually regular, and the sphincter ani acts properly. The sexual power is diminished, but not gone; for the patient has erections on waking in the morning, and occasionally emissions in his sleep. Seeing that there is functional energy of the bladder, rectum, and sexual organs, it appears evident that the disease has not spread to the posterior cornua of the gray matter, but is confined to the external portion of the white posterior columns, which Charcot and Pierret have shown to be the first seat of the lesion in progressive locomotor ataxy.

The patient has been treated with nitrate of silver for three months, and afterwards with the liquid extract of ergot and phosphorus also for three months. There has been very little change in his condition; the disease appears to have become arrested. No fresh symptoms have appeared, and the only improvement has been that the patient is able to get up from a chair more easily. Dr. Althaus has now prescribed the liquid extract of damiana, which he believes to possess a special action on the spinal cord, similar to that of ergot.

Case 2.—*Secondary Sclerosis of the Posterior or Crossed Pyramidal Portion of the Left Lateral Column of the Cord.*—C. B., aged forty, married, a fish salesman, was admitted under the care of Dr. Althaus on January 31, 1878. Seven years ago, while attending to his business, he had an attack, in which he to some extent lost his speech and the use of the left side. He could speak, but thickly and with an effort, and could walk a little, but kept falling down as he went on. He was taken into the London Hospital, but was unable to return to his business when he left it. Twelve months after the first attack he had another, which was more severe than the first, the paralysis being for a time more complete. He attributed his illness to anxiety and excitement in business, having had heavy losses just previous to the first attack. His parents were both extremely nervous people, and had died early; and he had for some time previous to the first attack suffered from headache and indigestion.

On examination it was found that his speech was somewhat thick and indistinct, but fluent, there being no loss of words. The patient's manner is peculiar, somewhat silly. His memory is impaired. The cranial nerves are quite healthy. There is loss of power and rigidity in the left side of the body. The arm appears abducted from the side, and the elbow, wrist, and fingers are held in a state of extension. There is great difficulty in flexing and supinating the arm, and in bending the hand and fingers; and considerable resistance to passive movements in that direction is experienced. The patient's gait is most peculiar, and closely resembles that kind of walk which found in spastic spinal paralysis. He walks on tiptoe with the left leg, which seems to be fixed as in a vice, so clumsy are its movements. The foot is inclined to scrape the ground, and there is tendency to fall forwards on that side of the body. The rigidity is chiefly marked in the rectus femoris, and there is difficulty in flexing the leg and foot. The reflex action of the skin is slightly increased, and that of the tendons, more particularly in the triceps of the arm and the rectus femoris, is considerably increased, which constitutes another point of resemblance with spastic spinal paralysis. There is slight wasting of the muscles, but not more than could be attributed to disuse; and the faradic and galvanic response is slightly less than on the healthy side. Sensation is not affected, and the thoracic and abdominal viscera are quite healthy.

Dr. Althaus gave the following account of the pathology of the case: There was at first hemorrhage in the right corpus striatum, owing to a rupture of one or several miliary aneurisms of the arterioles of the Sylvian artery, causing left hemiplegia. There was never any true aphasia, but only such impairment of speech as is met with independently of disease in Broca's convolution. In consequence of the hemorrhage, secondary sclerosis, such as first described by Türck of Vienna, set in in the posterior portion of the lateral column of the cord. This portion, which is now called Flechsig's crossed pyramidal column, is situated more posteriorly than the lateral column proper, and is composed entirely of fibres derived from the opposite cerebral hemisphere. This same portion of the lateral column is also the seat of that disease which has lately been described as spastic spinal paralysis (Erb), spasmodic tabes dorsalis (Charcot), and primary lateral sclerosis (Berger). There is thus no difficulty in explaining the physiological similarity in the symptoms observed in this case, which, except for its history, might be classed as one of spastic spinal paralysis. The cause and commencement of the two maladies are, however, quite different, the one being primary and the other secondary sclerosis Moreover, the gray patches which would be found in the cord of the present patient, should his case terminate fatally, would be seen not to be wedge-shaped, as in primary sclerosis, but more rounded; and they would be seen to spread exteriorly, not as far as the pia mater, which they do in primary sclerosis, but would stop short at some distance from that membrane. The patient is treated with a mixture of iodide of potassium and citrate of iron and quinine, and systematic gymnastic exercises, under which he is improving considerably.—*Med. Times and Gaz.*, Aug. 3, 1878.

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Resection of Knee-Joint; Recovery, with Useful Limb.—Susan H——, aged twenty-six years, housemaid, was admitted on Sept. 24, 1877, into Mr. West's ward in Queen's Hospital, Birmingham. The family history was good, except that the father died "consumptive."

In the month of May, 1874, she first noticed two lumps, one upon either side of the right knee. These did not disappear, and in a short time the whole knee-joint became swollen. She experienced pain in the part, especially upon exertion, and was compelled to take rest at intervals during the next three years. About three months before admission another swelling formed at the back of the joint. This she said, "gathered up and broke in about eight weeks, and discharged a large quantity of matter." No bone had ever come away. The patient could not give any history of injury, but she had had a great amount of kneeling. She had had no previous illnesses.

On admission the right knee was generally enlarged, and was slightly flexed. At the outer and back part of the head of the tibia there was the opening of a sinus, which passed downwards and forwards for about three inches. The patella was slightly movable, but there was no fluctuation across the joint. The lower end of the femur was slightly expanded, and the head of the tibia much more so. There was no redness of skin nor enlargement of the superficial vessels. There was great tenderness upon pressure. She was able slightly to flex the knee. The following measurements were taken:—

	Right limb.	Left limb.
Over the centre of the patella,	14⅜ in.	13 in.
2 in. above " "	13 in.	12½ in.
2 in. below " "	13⅜ in.	11 in.

A probe was inserted into the sinus, and, a counter-opening having been made, a drainage-tube was inserted, and a weight and pulley apparatus was applied. Temperature 103.7° F.

She continued to get worse during the month of October. The joint became more swollen; there was distinct fluctuation in the joint. The temperature continued high, with morning intermissions, being seldom less than 100°, and often rising to 103°. The appetite failed, and emaciation was becoming very marked. The pain increased, and became so great at night that it prevented sleep, and disorganization of the joint had evidently set in.

On Nov. 3d the joint was opened. A single straight incision was made across the joint, just below the patella, and a slice, half an inch thick, was sawn from the head of the tibia. As, however, the cancellated structure of that bone was very soft and carious, the gouge was freely used, so that a cavity was made in it large enough to contain a hen's egg. A small thin slice was then taken from the eroded articular surface of the femur, but the patella was left *in situ* after its surface had been slightly gouged. The operation was performed under Lister's antiseptic method, and the limb was put up in gutta-percha with Nathan Smith's splint before the patient was removed from the operating table.

The wound was dressed daily after the operation. The temperature remained high, especially at night, averaging about 102° F. during the first week. The sutures were removed on Nov. 7th, when the wound was found to be entirely united. The discharge was a bland yellow serum, without offensive odour.

Steady improvement in the patient's condition ensued, the pulse increasing in strength, and the temperature falling daily.

On Nov. 19th a plaster-of-paris case was applied from the toes to the pelvis to fix the limb immovably.

On Dec. 1st a small abscess, which had formed over the head of the tibia, was opened, and after that the limb was dressed antiseptically every second or third day.

During January the wound firmly healed with the exception of a small sinus at the outer angle, which did not, however, appear to lead to carious bone. Pain entirely ceased, appetite returned, the temperature fell to normal, and by the end of the month, when the plaster case was removed in order that a fresh one might be applied, the woman was able to lift the limb without assistance. On Feb. 4th she was discharged cured. She was able to walk about with a crutch, there being not more than one inch of shortening, the patella was slightly movable, and the front of the joint looked broad, firm, and strong. She had increased considerably in weight since the operation, and had taken no medicine except a little quinine and an occasional opiate, but throughout she had had a generous diet and four ounces of port wine daily.

Remarks by MR. WEST.—The above case illustrates the good result of antiseptic treatment of resection of the knee-joint, the advantage resulting from a very moderate division of the soft parts, a single straight tranverse incision giving ample room for the use of Butcher's saw in making sections of both the tibia and femur, and the increased strength and solidity given to the limb by the retention of the patella, and by constant immobilization of the parts by means of a plaster-of-paris apparatus.

There are several interesting features in this case. The joint disease had clearly resulted from inflammation of the head of the tibia, leading to caries, which had existed for a long time before she came under my care. All kinds of counter-irritants, combined with immobilization, had been resorted to without success. The whole of the structures of the joint were involved, but the greatest mischief was in the cancellous tissue of the head of the tibia. The patient's strength was exhausted, and hectic fever was quickly bearing her to the grave. This was obviously not a case for palliative or expectant treatment; the question that arose was, Had the poor girl sufficient stamina to go through the protracted convalescence which must necessarily attend resection of the knee-joint, or was it right, with a view of saving her life, which in November was in great danger, to resort to amputation of the thigh?

Having myself great faith in resection, especially in young subjects, and being extremely averse to amputate for almost any kind of joint mischief, without first making trial of resection of the affected joint, I determined to try what I could do for her by resection of the knee.

When I opened the joint, and discovered how largely the caries of the tibia had extended, I feared that I had made a mistake in endeavouring to save the limb, and that so much of it would have to be taken away that, if the patient did recover, which seemed somewhat improbable, it would be with a shortened and comparatively useless limb. Having, however, determined on resection of the joint, I carried it out, but having to remove so much of the tibia, I took away as little as possible of the femur, and I left, as I always do where practicable, the patella, to help to strengthen the front of the resected parts.—*Lancet*, July 20, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Yellow Fever and its Prevention.—Under the National Quarantine Act the medical officers of the United States Marine Hospital Service are required to assist the civil health authorities in all proper and practicable ways when requested to do so; and in view of this fact, and the prevalence of yellow fever in several of the inland cities of the United States, it has seemed proper to Surgeon-General Woodworth that he should make known to the medical officers of the Marine Hospital Service his individual views in reference to the disease and its prevention, which are not, however, to be regarded as having official force. They are as follows:—

"The weight of scientific evidence seems to warrant the conclusion that yellow fever is produced by an invisible poison capable of self-multiplication outside of the human organism, which it enters through the air-passages. The poison-germ or miasma is a product of the tropics. In this country, yellow fever has prevailed in most of the Gulf and Atlantic cities, and in many of the towns along the Mississippi River. In some instances it has been carried inland with the people fleeing from infected localities, but it has never shown a disposition to spread epidemically at points remote from the continuous water-roads of commerce, or to lodge in high salubrious places. The cities of the Great Lakes have always been free from the disease. Yellow fever cannot be said to be endemic in the United States, from the fact that in some years it does not appear, though the imported germ undoubtedly survives the mild winters. It appears to have about as much resistance of cold as the banana plant. When the banana stalk is killed down by the frost, the yellow fever does not recur until again imported. The germ is transmissible. It is capable of being transported in the clothing or personal effects of passengers and sailors, but its spread from one city to another is chiefly accomplished by vessels—their damp, filthy holds and bilge-water being its favorite lurking-places. Confinement, moisture, and high temperature favor the multiplication or virulence of the poison. When a wharf, or spot of ground, or a house, becomes infected, the poison at once commences to spread, creeping slowly in all possible directions, continually enlarging the area around the centre of infection, unless checked by disinfection, as has undoubtedly been done by the use of carbolic acid in New Orleans in former outbreaks. Yellow fever is not communicated from the sick to the well; the sick and well being dangerous only as possible carriers of the poison-germ or miasm. In support of this assertion it may be stated that at quarantine hospitals, where the effects of yellow fever patients are burned, or otherwise thoroughly disinfected before the admission of the patients, the attendants do not contract the disease. This has been demonstrated many times. All well persons whose effects have been disinfected may be considered harmless after six or seven days have elapsed from the time of leaving an infected district or vessel, as the period of incubation of the disease lasts from two to six days. This simplifies the question of quarantine—absolute land-quarantines being deemed impracticable—and indicates the direction of preventive measures to the vessel, cargo, or the locality, if the poison have found lodgment on shore. A vessel may escape infection if kept clean and dry, and all parts capable of being closed are frequently subjected to the fumes of burning sulphur, and the men employed on board are compelled to bathe and change their flannels daily, and not allowed to sleep on deck or in the hold of the vessel. There is an example of a ship trading between Havana and New York, upon which these precautions have been enforced for a period of twelve years, and not a single case of yellow fever has occurred on board Though not sufficiently demonstrated to state as a fact, still there seems good reason to believe that much may be accomplished by individual prophylaxis:—by the use internally of small doses of sulphate of quinia at regular intervals, and of tincture of iron and chlorate of potassa. As the poison enters the system through the air-passages it has been suggested that the nasal passages be bathed frequently with a solution containing quinia, to be applied by means of a nasal spray."

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The Progress of the Yellow Fever Epidemic.—From the official report of the Surgeon-General of the United States Marine Hospital Service for the week ending August 24th, we learn that at New Orleans during the week ending at noon on August 23d, there were seven hundred and seventy-one cases of yellow fever and two hundred and ninety-five deaths—making in all sixteen hundred and seventy-three cases and five hundred and thirty-four deaths. During the twenty-four hours to noon, Aug. 23d, there were one hundred and twenty-three new cases and forty deaths.

At Vicksburg there were at least four hundred cases of yellow fever from date of commencement, Aug. 12th, to evening of 23d, and sixty-nine deaths. Aug. 23, there were twenty deaths.

At Memphis there were one hundred and forty-four cases of yellow fever and fifty-three deaths during six days to Aug. 23d.

At Canton, Miss., the first case of yellow fever occurred on Aug. 1st. To Aug. 23d there were eighteen cases and eight deaths.

The first case of yellow fever originating in Port Gibson, Miss., occurred Aug. 3d, resulting in death, Aug. 8th. The disease began to spread Aug. 14th. One hundred and eighteen cases and nine deaths to Aug. 23d.

To Aug. 23d no more cases of yellow fever had developed at Cincinnati since the two mentioned in the preceding weekly report. The engineer of the steamer "Golden Rule" was admitted to the hospital on the 22d instant with yellow fever, and also one other case, probable yellow fever, from Memphis.

At Morgan City, La., there was one case of yellow fever, Aug. 21, a patient from New Orleans.

At Ocean Springs, Miss, there are reported three cases of yellow fever and one death—all imported.

Four refugees died of yellow fever at St. Louis during the week ending Aug. 23d.

At Louisville four river-boatmen suffering from yellow fever are under treatment.

Dispatches to the 23d instant report good health at Mobile.

From Key West we learn that no yellow fever has appeared for three weeks to yesterday evening.

At Grenada, Miss., so many of the remaining population are stricken with the fever that definite information of the number of cases and deaths cannot be obtained.

At Havana ninety deaths from yellow fever and six from smallpox are reported for the week ending Aug. 17th.

At Matanzas the cases of yellow fever have decreased. Only five American vessels in port Aug. 16th, and all of them have either had, or were having, cases of yellow fever on board.

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American Ophthalmological Society.—The annual meeting of this society was held at Newport in July last. The following officers were elected for the ensuing year: President, H. D. Noyes, M.D., of New York; Vice-President, Wm. F. Norris, M.D., of Philadelphia; Secretary, R. H. Derby, M.D., of New York.

American Otological Society.—The annual meeting of this society was held at Newport, on July 24th, and the following officers were elected for the ensuing year: President, Albert H. Buck, M.D., of New York; Vice-President, Dr. Chas. H. Burnett, of Philadelphia: Secretary, Dr. J. Orne Green, of Boston.

Oregon State Medical Society.—The fifth annual meeting of this Society was held at Portland, June 18th, when the following officers were elected for the ensuing year:—President, H. Carpenter, M.D., of Salem; Vice-President, Dr. F. A. Bailey, of Hillsboro; Secretary, Dr. Curtis C. Strong, of Portland.

Medical Degrees for Dental Students.—Arrangements have been made with the Jefferson Medical College whereby students of the Philadelphia Dental College and of the Pennsylvania Dental College may obtain the two degrees of D.D.S. and M.D. in three years. Dental students taking the degree of M.D. will be required during the second year to pursue extra studies in surgery, practice of medicine, and obstetrics, and the third year will be entirely devoted to medical studies.

FOREIGN INTELLIGENCE.

Catgut Ligatures.—Dr. J. C. OGILVIE WILL, Surgeon to the Aberdeen Royal Infirmary, makes the following report (*Lancet*, July 20, 1878) concerning some experiments on catgut steeped in chromic acid:—

During the last few months I have conducted a number of experiments with catgut steeped in solutions of chromic acid of varying strength, the material being kept in the solutions for a given number of hours with a view to obtain a substance which, while capable of being absorbed, might be relied on as possessing sufficient endurance, if I may so put it, to last until its use could be dispensed with; but this I have as yet failed to obtain, the weakest solution of chromic acid seeming to so tan the catgut that its solution and absorption is rendered impossible. Still chromic-acid catgut sutures, similar to those used in the foregoing case, are of great value in a very large class of cases, and may be regarded as perfectly reliable substitutes for silk or wire, as, with the single exception of absorbability, they will be found to meet all the requirements of this mode of keeping cut parts in apposition. For chromic-acid catgut possesses the advantage of a maximum degree of strength combined with a minimum of size, and it is absolutely non-irritating. I have now used it in a great variety of cases, from major amputations to minute excisions, and in no case have I had reason to regret its employment. I do not mean it to be understood that in every case it has held the parts together until union has resulted, but that it has proved lasting and non-irritating in all; for example, in a case of amputation of the thigh, where union did not take place by first intention, the sutures soon became detached from the edges of the posterior flap, but some of them were allowed to remain attached to the edges of the tissues forming the anterior flap, without occasioning the slightest degree of inflammatory irritation. The mode of preparation I have hitherto found most reliable is this: I take a few yards of thin, common, unprepared, dry catgut, and place it in a wide-mouthed phial containing glycerine and carbolic acid (one part of acid to seven of glycerine), and, after steeping for a week or longer, the catgut is transferred to a vessel containing chromic acid, acetic acid, and water (one per cent. of chromic, and twenty-five per cent. of acid). At the end of seven hours the catgut is taken out and dried. During the drying process it is prevented from curling up, or getting rough and uneven, by using tension, the gut being stretched by winding it round two nails driven into a piece of wood, a foot or two distant from each other. In the course of a few hours it will be found ready for use.

Catgut, thus prepared, is a brownish-black, perfectly smooth material, possessing great strength, yet not much thicker than what is sold in bottles as "fine" antiseptic catgut ligature. The mode of preparing tanned catgut may possibly be already well known; but, as I have not yet seen any description of it,[1] it occurred to me that a detailed notice of it might prove useful to those seeking for a reliable substitute for the materials commonly employed for sutures.

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Thrombosis of the Veins in its Surgical Relations.—Dr. Azam, of Bordeaux, terminates a paper (*Gaz. Hebd.*, July 19), read at the Société de Chirurgie with these conclusions: 1. Thrombosis is possible after fractures, contusions, phlebites, varices, chronic inflammations in the vicinity of large vessels, accouchements, and through compression exerted on the veins by neighbouring tumours undergoing rapid development. 2. Thrombosis suspected by reason of the œdema of parts situated below is ascertained by direct exploration along the tracts of the efferent veins. 3. The detachment of migratory coagula may be induced by an exaggerated exploration of the veins, by massage of the affected limbs, or by the sudden removal of the compression of a thrombosed vein. 4. The accidents producible by migratory coagula are variable according to the dimensions of these. They may consist in mere uneasiness, pleurisy with limited effusion, partial pneumonia, hæmoptysis, syncope, asphyxia, or sudden death. 5. The surgeon may prevent the formation of venous coagula in avoiding as far as possible the slow compression of large veins, in respecting with the greatest care their inner coat, and in hastening the cure of chronic or deep-seated inflammations situated near veins. 6. When thrombosis is confirmed, he should endeavour to prevent the detachment of coagula by impeding local and general motion, and discharging all collections of liquid near veins so affected.—*Med. Times and Gaz.*, July 27, 1878.

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Epidermic Grafting in Coloured Races.—At the Société de Biologie (*Gaz. Hebd.* July 5), M. Maurel stated that during a two years' residence at Guiana he had made numerous experiments on epidermic transplantation, placing the grafts on persons of different race and colour. He found that not only did the graft take well, whatever description of transplantation was made—whether transported from the skin of a black to that of a white, or the reverse—but that there always remained a whitish line at the point of junction, wherein pigmentation was not produced. The pigment disappeared when a graft was transplanted from a black to a white person; but when the two individuals were highly coloured, the graft remained black except at the point of cicatrization.—*Med. Times and Gaz.*, July 13, 1878.

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The Brain in Atrophy of the Arm.—M. Marc Sée has presented to the Société de Chirurgie the brain from the body of a man brought into a dissecting room, of which the right arm was atrophied as if from infantile paralysis. A marked difference in size existed between the right and left ascending parietal convolutions; the former being of normal size, and the latter considerably smaller. M. Sée asks whether this is a mere coincidence or not, and does not venture to give an answer in the face of the contradictory opinions of MM. Charcot and Luys on the subject. The case is, however, of much interest on account of its coincidence with that recently brought by Dr. Gowers before the Medical and Chirurgical Society, in which an atrophy of the middle third of the same convolution coexisted with a congenital absence of the hand on the opposite side.—*Lancet*, June 8, 1873.

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Pulverized Sea-Water. — Prof. Mantegazza states (*Gaz. Med. Lombard.*, March 30) that he has derived great advantage from the employment of pulverized sea-water in cases of chronic non-specific laryngitis, obstinate chronic pharyngitis, bronchial catarrh from chronic bronchitis with or without bronchial dilatation, the first and second stages of phthisis, caseous pneumonia, and chronic pneumonia of different forms accompanied by profuse bronchial expectoration, and various forms of scrofula. He does not advise it in those forms of phthisis which pursue a rapid course and are accompanied by much febrile action and great bronchial irritation. In all doubtful cases trials may be made of a few inhalations, which, if they do no good, do little or no harm. Pulverizations of sea-water are now executed at several establishments in Italy, but prominent among these is that of Rimini, where they are conducted on so large a scale that twenty persons may receive them at the same time, the pulverization being effected by means of compressed air and a steam-engine. The *sedute* lasts for half an hour at first, and afterwards for an hour, from thirty to forty of these being required. The patients while respiring the vapour should be encouraged to talk and sing as far as their strength allows. The first effects produced are a pleasant excitement and a return of appetite.—*Med. Times and Gaz.*, May 18, 1878.

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[1] Some interesting facts concerning the preparation of catgut ligatures, brought before the International Medical Congress held at Philadelphia in 1876 by Professor Lister, and the composition o the fluid he employs for the purpose, may be found in the Transactions of the Congress, p. 538.

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Metallo-Therapeutics.—There is no abatement abroad of interest in the subject of "metallo-therapeutics," and enthusiastic scientists are continually taking up the matter and producing wonderful results, which, it must be confessed, do not seem to be the clumsy conjuring that some think them. Whatever opinion may be held as to the meaning of these effects of metallic applications, it is of prime importance to note that their study is not undertaken by clever charlatans, but by men of known powers of observation. One of the most recent accounts of the effects of metallic therapeutics is that of M. Abadie in a short paper on Hysterical Amblyopia (*Prog. Méd.*, July 13th). He points out that many cases of so-called "congenital amblyopia," when vision is not wholly abolished, when the failure is chiefly in the centre of the field, and when the duration of the amblyopia may be almost indefinite, depend on anomalies of refraction, others on congenital defect in the optic nerve, whilst others are probably more strictly of the hysterical type. He further points out that hysterical amblyopia is not always associated with prominent hemianæsthesia nor with the pronounced symptoms of grave hysteria, but is often almost the only functional derangement present. Three cases of so-called congenital amblyopia which he had recently seen proved to belong to the hysterical category; they were associated with some hemianæsthesia, the loss of sensibility being limited to the side of the amblyopia (which is almost invariably unilateral). Application of gold to the temporal region of the amblyopic side not only increased the acuteness of vision, but was accompanied by a diminution in that of the unaffected eye. A similar transference of sensation was observed with regard to the cutaneous sensibility. It is a phenomenon first pointed out by Charcot, and is one of the most remarkable facts in the observations of these cases.

Besides unilateral amblyopia with hemianæsthesia there are other ocular nerve disorders traceable to hysteria, and, according to M. Abadie, amenable also to metallic applications. The frequent complaint of women that they cannot look at any object for any time without suffering severe pain in the head, and photophobia, and the constant burning and pricking sensation experienced in the conjunctiva and eyelids without any change being noted in the fundus and without any anomaly of refraction, belong to a class of functional visual derangements, which has been variously said to depend on asthenopia of accommodation or upon retinal hyperæsthesia. Förster, of Breslau, has recently studied these cases, and styles them hysterical kopiopia, and shows that they are usually associated with some slight uterine disorder. In such cases menstruation is deranged, abdominal pains are complained of; but the chief trouble is that produced by reflex phenomena, which far outweigh the local disturbing cause in their effect on the patient. Many young women are wholly unable to read, write, or sew in consequence of the troublesome functional derangement of their visual organs. The treatment for these cases of "uterine kopiopia" consists in measures for the uterine affection itself, hydrotherapy and bromide of potassium, and in some cases "metallo-therapy." M. Abadie has found that in cases of this class which are truly hysterical the effect of metallic applications is very striking. Thus there are cases in which continuous headache, neuralgia increased by the least work, and not yielding to quinine, have been cured by the simple means of application of a metal. Gold is the first metal to be tried. "Three twenty-franc pieces" are tied on to the forehead, and kept there during the night. If relief comes with the morning, then the metal is administered internally in the form of the chloride, at a dose of about a centigramme. Should gold fail, then copper, zinc, or combinations of metals are tried until eventually a cure is effected. An illustrative case is given, and with an abstract of this we may leave, for the present, the subject of metallic medicine. The patient was a young lady, twenty-five years of age, who for nearly a year had suffered from asthenopia, inability to view near objects without severe pains in the head, photophobia, and transitory œdema of eyelids in the morning. The eyes were perfectly normal in every respect. Tonics, baths, and bromide of potassium produced no effect, and at the end of two months M. Abadie saw the patient again. He then learnt that she suffered from abdominal pain at the catamenial periods, when also the ocular disorder was most marked. There was no anæsthesia nor amblyopia, yet he thought it well, after the failure of other remedies, to have recourse to the metallic treatment. He applied gold externally and administered it internally. The latter mode of exhibition provoked gastric disorder, and, no relief ensuing at the end of a month, copper was had recourse to. The day following the application of copper the photophobia had disappeared and the œdema of the eyelids did not develop, and the patient thought herself so well at the end of a month as not to require any more of the treatment. It was left off, and the symptoms returned. She herself had recourse to the cupric treatment, but this time no good resulted. Finally, M. Abadie effected a rapid and complete cure by applying a combination of copper and zinc externally in the form of two thin plates of these metals.

It is evident that metallic medicine is not yet a thing of the past, for the same number of the journal containing this communication states also that MM. Charcot and Regnard contributed to the Société de Biologie a paper on the subject with reference to hysterical hemianæsthesia; and the journal itself promises to discuss the matter again shortly. Whatever the explanation, the subject is not one to be passed over in silence.—*Lancet*, July 20, 1878.

Canada Medical Association.—The eleventh annual meeting of the Canada Medical Association will be held in the city of Hamilton, Ontario, on Wednesday, 11th of September.

OBITUARY RECORD.—Professor BARTELS, of Kiel, a distinguished physician, died in the latter part of June. He made an especial study of renal diseases, and in England he will probably be best known by the volume on the Kidney in Ziemssen's "Cyclopædia of Medicine," and by an excellent lecture on the Diffuse Inflammations of the Kidneys in Volkmann's *Sammlung klinischer Vortrage.—Med. Times and Gaz*, Aug. 3, 1878.

—— At Vienna, on the 23d of July, aged 74, KARL ROKITANSKY, Curator of the Imperial Pathological Museum, and late Professor of the University of Vienna. Rokitansky's reputation as a pathologist is world-wide, and his great work on Pathological Anatomy, which was completed in 1846, is still a standard authority in all matters relating to gross lesions.

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PROCEEDINGS

OF THE

AMERICAN GYNÆCOLOGICAL SOCIETY.

(Specially reported for the MEDICAL NEWS
By FRANK WOODBURY, M.D.)

The third annual meeting of the American Gynæcological Society was convened in Philadelphia, September 25, 1878, and continued in session for three days. The meetings were held both morning and afternoon, at the Hall of the College of Physicians; they were full of interest, and were largely attended by the Fellows of the Society and the profession at large. The entire active membership now amounts to only forty-three, being limited by the Constitution to sixty.

First Day.—The meeting was called to order at 10.30 A.M., by Vice-President Dr. WM. GOODELL. The Secretary, Dr. JAS. R. CHADWICK, announced the receipt of invitations to visit a number of public institutions.

Dr. ALBERT H. SMITH, of Philadelphia, then delivered a brief address of welcome.

Dr. J. C. REEVE, of Dayton, reported a *Case of Rupture of the Perineum without Implication of the Vulva* in a multipara; no cause for the recto-vaginal rupture could be assigned except a precipitate labor; the fœtus being rapidly delivered through the rectum while she was sitting on a vessel. Such cases are rare. Where such an accident occurs it is almost always in a primipara; when it is encountered in a multipara it is generally found that there are some bands of vaginal cicatricial tissue, or other abnormal condition, preventing natural delivery. The accident may generally be prevented by prompt treatment. Dr. Matthews Duncan recently reported a series of cases where this condition was averted by the use of the forceps, and Dr. Fordyce Barker a case where the arm protruded through the anus, but the child was delivered by the vagina. Laxity of the perineum has been theoretically suggested as a cause for central rupture, but if this were true it should occur most often among multipara, which is not the case. In the subject of the report there was not marked relaxation of the perineum. The wound was brought together with the quilled sutures, which were afterwards cut between the stitches to make them lie smooth.

Dr. JAS. P. WHITE, of Buffalo, believed this form of rupture could be prevented, generally, by making bi-lateral or tri-angular incisions of the perineum, whenever laceration is threatened. He reported a case, in which such incisions were made and no laceration occurred. The same patient falling in labour again, it was decided to leave it to nature, when, in spite of the greatest care, a tear occurred, not in the line of former incisions but directly back into the rectum. These incisions are simple, free from danger,

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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and readily heal; they are very valuable and should be more generally practised.

Dr. Reeve, of Dayton, remarked that in cases of torn perineum, the operation should either be performed immediately after the labour, or if this cannot be done it should be delayed several months to let the wound contract as much as it will.

The paper of Dr. J. Marion Sims, *On the Surgical Treatment of Stenosis of the Cervix Uteri*, was of considerable length. Dr. Sims being absent, abstracts from the article were read by the Secretary.

In operating the patient should be placed in Sims's position, the duck-bill speculum introduced, the uterus seized and pulled down with a tenaculum, when antero-posterior incisions are to be made with Sims's knife in the posterior and anterior lip. The dilator may now be introduced, if thought necessary, and, the uterus being restored to its place, the canal dilated to the desired extent. Pulling the uterus down again with a tenaculum a glass plug is placed in the uterine canal, a pledget of cotton wet with solution of alum placed against the cervix, and the vagina packed with cotton-wool. The patient remains in bed, and a catheter is used for a day or two. He has abandoned iron as a styptic, and uses a solution of alum (1 to 12) with carbolic acid (1 to 40). Has had two cases of hemorrhage, both due to want of proper care in the after-treatment. Serious bleeding sometimes follows the metrotome caché, but no operation is unaccompanied by danger. When the flexion is so great that the knife cannot be readily introduced a grooved director should be used. In cases of dysmenorrhœa caused by uterine flexion, especially where the posterior lip is thick and long, the Sims's operation is particularly serviceable. The passage of a medium-sized sound into the uterus does not prove that there is no necessity for the operation, for the canal may be nearly closed by the flexion so as to produce symptoms of stricture. One of his cases died of peritonitis following hemorrhage from displacement of plug in getting out of bed; another died from the bursting of an abscess in the Fallopian tube, the patient having had chronic salpingitis. Pelvic cellulitis may appear on the fifth or sixth day; to prevent this antiseptic precautions are recommended during operation. The paper establishes the following points:—

1. The bi-lateral operation is adapted to relieve those cases of mechanical dysmenorrhœa, where the lips of the cervix preserve their normal relations, and the os points directly backward.

2. The antero-lateral incisions are best in cases where the posterior lip is markedly hypertrophied, so that the cervical canal apparently corresponds with the long axis of the vagina.

3. The bi-lateral operation is Simpson's.

4. The antero-posterior operation belongs to Sims.

In opening the discussion upon the paper Dr. Fordyce Barker said that it is now nearly thirty-three years since Sir Jas. Y. Simpson first suggested and perfected the bi-lateral incision for the cure of dysmenorrhœa and sterility, and it is nearly twenty years since Sims introduced and perfected the antero-posterior incision for certain forms of stenosis of the cervix, and it must be acknowledged that there are yet wanting precise rules for recognizing the conditions requiring the operation. Why is it that one operator finds it necessary to perform it 383 times, another over 300 times, and the author of the paper nearly one thousand times, while others with equal opportunities for observation, and equally capable, consider it rarely necessary? The fact that the operator who had performed it the most frequently thinks that such precise rules as he has laid down are necessary, shows that it is not free from danger.

There has prevailed a mania for incision of the cervix uteri by which great injury has been done. Deaths have occurred even in such skilful hands as Dr. Sims's, but in less experienced hands many cases of death have doubtless occurred, which have never been reported. The speaker himself was cognizant of sixteen deaths from this operation in the city of New York alone, and it must be conceded that many others must have occurred elsewhere which have not been published.

The practical question is that of treatment. We are all prepared to admit that stenosis producing dysmenorrhœa should be treated, and would even justify an operation of some severity. The special one proposed is always attended with some danger, and the greater the experience of the operator the greater caution does he learn to use in performing it; but "fools rush in where angels fear to tread," and the inexperienced rashly undertake it in unsuitable cases, and harm often results. The object aimed at by the operation is to allow the menstrual fluid to pass out; and, secondly, to permit the free passage of the fecundating element; and sometimes to straighten the canal of the cervix. How is it that some have become enthusiastic in favour of the operation, and others of equal ability think it necessary to perform it less and less? Is it because those who become great operators are placed in a position not to judge correctly of the results of their own operations? Let us suppose a case that falls into the hands of a skilled surgeon. She is placed in the care of a trained nurse at the hospital; she receives daily visits from the physician, and is fully under his control; temporary improvement is almost sure to occur. After she leaves, if the operation prove a success, there is no danger that he will not be acquainted with the results; if it is unfavourable there are many reasons why the operator will not learn of it, as the case falls into the hands of other physicians. In the last fifteen years the speaker had seen at least 100 cases where incision of the cervix had been unsuccessfully performed for the treatment of sterility; performed both by eminent men and others not so well known to the profession.

Dr. ELLWOOD WILSON, of Phila., said he was not an advocate of the operation, but prefers dilatation with the forceps, from which he had never seen any bad results, and his success, as a rule, was satisfactory. The patient keeps her bed for 24 hours, and the only after treatment required is a tepid soap and water injection.

Dr. NOEGGERATH, of New York, remarked, that this operation is not performed as frequently as it used to be, is largely due to the efforts of the late Dr. Peaslee. He would add two objections. In a case of ante-flexion of the second degree it is readily seen that, while this incision of the cervix is made to straighten the canal, it cannot do it. Secondly, an incision carried into the parenchymatous structure of the uterus, where there are lymphatic glands and vessels, may lead to inflammation and septicæmia. The normal calibre of the internal os is one-fifth and of the outlet one-fourth of an inch, and it is never necessary to go beyond the normal size of the canal. Peaslee's operation accomplishes all that is required. In order to determine the comparative value of these expedients statistics should be prepared giving the condition of the patients, say two or three years afterward. He has a plan now under trial, but will not report it until sufficient time elapses to enable him to test its value. The tendency is to supplant cutting operations by others less dangerous, but which give equally successful results.

Dr. H. P. C. WILSON, of Baltimore, urged that the cases should be selected. When the uterus is bent upon itself and the posterior lip elongated, dilatation is often sufficient and accomplishes as much good as division. He has operated on nearly 100 cases with only one death, which occurred from peritonitis on the 14th day, after eating indigestible food. The danger of this operation is in not selecting proper cases, and is not so great as might be inferred from what has been said.

Dr. T. A. EMMET, of New York, had, in years past, performed the operation probably as often as any one except Dr. Sims. Observation has taught him that where the flexion is above the vaginal junction it is an expression of trouble elsewhere, the cause of which is not in the uterus itself. The uterus may be bound down by pelvic cellulitis, the result of inflammation. He never saw a case of this kind permanently relieved by an operation. Examination through the rectum will often in such cases reveal thickening of the broad ligament. The fault is not in the uterus, nor is it ever relieved by an operation. There is a certain class of cases in which the neck of the uterus is developed out of proportion to the body. At the period of puberty the elongated uterus bends forward, becomes anteverted, and, from the pressure of the viscera, afterwards becomes anteflexed. In these cases dysmenorrhœa occurs at each period and continues to the end. In other cases dysmenorrhœa is due to constitutional causes, and after the first effect of the operation is over the dysmenorrhœa will return. If the condition is due to pelvic cellulitis, the operation will pass out of use and we will never hear of it again.

A case of Extra-Uterine Pregnancy, with discharge of Fœtal Bones through the Bladder was reported by Dr. James P. White, of Buffalo, who endorsed the opinion of Dr. Parry, that it is better not to operate on such cases but leave them to nature.

Dr. John L Atlee, of Lancaster, reported, as an exception to this rule, a case operated upon by Dr. Walter F. Atlee, to be published in the October number of the *American Journal of the Medical Sciences.* He believed that when the health of the patient is failing it is proper to operate. If, in these cases, the placenta be allowed to remain the operation may become as safe and popular as ovariotomy.

Dr. D. Humphreys Storer, of Boston, reported a case where, in the course of three months, all the bones of the fœtus were passed by the rectum. The patient has had two children since.

Dr. White did not mean to say that no operative means should be instituted, or that the abdomen should not be opened, but that the rule should be not to interfere until circumstances demand the operation. By this time adhesions will have formed which will point out the line for our incision. The child is never saved.

Dr. T. G. Thomas, of New York, reported four cases. He removed two through the vagina early in pregnancy. Unfortunately both died. Now he would leave them until nature calls for interference.

Dr. H. F. Campbell, of Georgia, also favoured non-interference, and mentioned a case where a part of a mutilated fœtus being left in the uterus it ulcerated through its wall and was subsequently discharged through the abdominal parietes.

In the afternoon, Dr. J. T. Johnson, of Washington, reported a case of *Head and Foot Presentation in which a Fracture of the Spine occurred in Utero.* Delivery was accomplished by Simpson's forceps.

Dr. Engelmann, of St. Louis, referred to a case where fracture of several bones took place some time before delivery. The child was born with a great number of bones broken, with others in the process of healing, united by callous. There is no history of injury to the mother, and the cause was unknown. The child was still-born.

Dr. Noeggerath had a case in which there was fracture of the humerus and of the thigh. The same child before her fifth year had thirty-two fractures. The bones were fragile, and slight causes produced fractures. At thirty-two years of age she was delivered by Cæsarean section, her pelvis being contracted to one-quarter of an inch. It was an extreme case of rachitic softening of the bones.

Dr. Penrose, of Philadelphia, in a case of placenta prævia with head and foot presentation, had adopted a novel expedient to accomplish rapid delivery. By slipping a fillet over his hand he succeeded in placing it around the presenting foot. Dr. Fish, who was in attendance on the case, made steady traction on the fillet, downward and backward while the speaker pushed the head upward with one hand in the vagina aided by the other placed over the abdomen. Thus he was able to accomplish turning and delivery in a few minutes. The difficulty was increased by the placenta prævia, and he considered the method invaluable.

Dr. T. A. Emmet, of New York, read a paper entitled *The Necessity for Early Delivery as Demonstrated by the Analysis of One-hundred and Sixty-one cases of Vesico-vaginal Fistula.* This was accompanied by a carefully prepared tabular statement showing the number of hours in labour, the details of treatment under different modes of delivery—under the use of forceps, ergot and forceps, craniotomy, version and craniotomy, version alone, version and the forceps, and the results from other artificial means, compared with each other and with cases of natural delivery.

From the results given it would appear that vesico-vaginal fistula is generally due not to the use of instruments but to delay in the second stage of labour. A full bladder was declared to be a very common cause. A large proportion of the cases had been attended by midwives; the accident being comparatively rare among the better classes. In the table it was shown that in 70 cases it was nearly two weeks before the slough occurred, in 50 others urine escaped on the introduction of the forceps. The catheter should always be passed before putting on the forceps, and a male catheter may be found necessary. The loss of tissue is not in proportion to the violence of the pressure but its duration. The forceps should be applied as soon as the head remains stationary and does not recede after a pain. At this moment the danger to the woman begins, and delivery should be speedily accomplished. Of the 161 cases of operation 146 were cured, 9 improved, in 3 nothing was done; 1 died of other disease, and in 2 the result was not known.

Dr. A. H. Smith, of Philadelphia, said the number of cases of vesico-vaginal fistula have greatly diminished since the use of the forceps has become general. It is certainly strong testimony to the value of the forceps that was given by Dr. Emmet in the statement that he had never seen a case of vesico-vaginal fistula occur from the use of the forceps. In nearly 11,000 cases treated by the Philadelphia Lying-in Charity, where it was the standing rule to apply the forceps early, only one case of vesico-vaginal fistula occurred: in this case there was a rupture of the anterior wall of the uterus extending into the bladder. He agreed with Dr. Emmet that the danger was not in proportion to the duration of the labour nor to the amount of pressure, but to the length of time that the head was allowed to remain stationary, pressing against the pubic symphysis. When pressure becomes continuous, instrumental interference is required. As long as there are no evidences of acute metritis, or other local or constitutional dangers from exhaustion developing, as shown by increase of temperature, frequent pulse, etc., it is better not to interfere with the course of the labour, during the first stage, but in the second stage delay becomes dangerous. He inquired as to the rule of practice where the head is pressed against the symphysis and the metallic catheter cannot be introduced without force, and the head impacted too low to be pushed up, should delivery be accomplished without first evacuating the bladder, or should the head be promptly drawn down rapidly by the forceps from the position at which it presses upon the bladder and urethra, thus relieving the pressure and diminishing the danger of a slough?

Dr. Storer, of Boston, had attended several thousand cases of labour with only two cases of this accident. He strongly urged that the forceps should not be used unless impaction occur.

Dr. Fordyce Barker, of New York, said that no statistics have been brought forward for a number of years having such a bearing on practical obstetrics as these. Prepared by a person not prejudiced in favour of any treatment, and not having any theory to support, it throws valuable light upon a most important question. Although no new teachings are brought out by the paper, yet we find its results fully in accord with the most advanced obstetric teachings of the present day, and nothing has been presented that so well demonstrates the fact that these teachings are true, and that so well illustrates what they are doing for suffering woman. An over-distended bladder may cause delay in labor, not only from the mechanical obstruction, but also from the intense suffering caused by the pressure of the head upon the bladder at each uterine contraction, until by a reflex influence upon the uterus the extrusive force becomes insufficient. In cases of retarded labour, if the catheter is introduced the labour will often advance rapidly. Without heeding the statements of patient or nurse, he always used the catheter before applying the forceps. In the condition supposed by Dr. Smith, the forceps should be applied so as to take off the pressure from the symphysis pubis and evacuate the bladder before delivery. An over-distended bladder increases the shock to the patient, increases the liability to post-partum cystitis, and often leads to pelvic cellulitis.

Even the first stage of labour, if protracted, is not without danger to the patient, by exhausting nerve-power and preventing the patient from sleeping, and by reducing the morale may prolong the second stage. Rest should be secured by large doses of opium and camphor. In some cases of delay he advocated rousing up the uterus by a large dose of quinia, which does not, however, exert the oxytocic power of ergot. The dangers of the forceps have been greatly over-estimated. In his experience he had never regretted using them, but recalled cases where he regretted not having used them. He dissented from the principle that the forceps should be applied as soon as the head ceases to recede. This depends on the position taken by the head in the pelvis and the condition of the soft parts, and may even happen in normal labour. He would rather say that they should be applied as soon as the head ceases to advance, the uterine contractions continuing in force.

Dr. J. L. **Atlee**, when a student of medicine in Philadelphia, a little more than sixty years ago, learned from his uncle, Dr. A. L. Atlee, who was the first who publicly made known the danger of the use of ergot in primiparæ, that this is more frequently the cause of vesico-vaginal fistula than any other cause that can be imagined. In such cases he prefers to use the forceps. The older he becomes the more apt he is to use the forceps.

Dr. **Storer** thinks that all who have spoken are agreed on one thing, that when the head ceases to advance we should apply the forceps. We condemn their indiscriminate use without positive indications, as in inexperienced hands they are liable to produce accidents. He has not seen a case of lacerated perineum where the forceps had not been employed.

Dr. **White**, of Buffalo, said that where laceration of the perineum is threatened the forceps should be applied to control the head. We get our fear of the forceps from English teachings; but a great revolution is taking place in England on this point. In looking over the statistics we find one of the older authors applied the forceps to one in six hundred cases. But in a paper recently presented to the London Obstetrical Society, which was received without dissent, the proportion of cases requiring the forceps was stated to be one in ten.

Dr. **Emmet** said that in cases of labour delayed by distension of the bladder the child is generally still-born. In the case of impaction, where the catheter cannot be introduced, he would recommend the use of the aspirator to draw off the urine, as is frequently done in the male. He would insist that the woman must be delivered as soon as the head ceases to recede. He requested Dr. Barker to define under what circumstances the head ceases to recede, except from loss of elasticity of tissues.

Dr. **Barker** said that the experience of every one shows that this depends often upon the position of the head—when the head is rotated anteriorly at an early period of labour; and it never takes place in cases of occipito-posterior positions. The head ceasing to advance furnishes the indication for applying the forceps.

Dr. **Goodell** agreed with Dr. Smith and Dr. Barker that the catheter should be introduced before delivery by the forceps. He would not recommend a hasty application of forceps by young men. While Drs. Smith and White may save the perineum, an inexperienced practitioner would tear it. Lacerations of the neck of the uterus, in his experience, were generally caused by the use of the forceps.

Second Day.—Dr. H. P C. **Wilson**, of Baltimore, reported a case illustrating the value of the *Hand as a Curette in Post-partum Hemorrhage.* In a case of obstinately recurring hemorrhage ergot had been ineffectually given to the extent of one ounce and a half, by the mouth, hypodermically, and by the rectum; ice and manipulation also had failed, when scraping the placental surface permanently checked the bleeding, and a good recovery followed.

Dr. R. A. F. **Penrose**, of Philadelphia, read a paper on the *Treatment of Post-*

partum Hemorrhage, in which he recommended a plan of treatment which had never failed in his hands. The idiosyncrasy of a weak uterus is the great predisposing cause to uterine inertia, which usually accompanies post-partum hemorrhage. Plethora, in some cases, undoubtedly favours the accident. The existing causes are well known, and need not be dwelt upon. The curative treatment, since the hemorrhage depends upon different conditions, must necessarily vary with the nature of the case. Ergot, friction and pressure, irritation of vagina and interior of uterus, etc., the effects of impression made upon distant organs, such as the stomach; and the use of stimulants, opium, or oil of turpentine are often necessary. When, in spite of our ordinary remedies, the rectum refuses to contract, in certain cases the application of a solution of the persalts of iron or of tincture of iodine may be justifiable. The agent which he has found to be *the* remedy for post-partum hemorrhage is common vinegar. He has had only one case of death follow its use, but this could not be attributed in any degree to the injection. This treatment is not original, but it is convenient, safe, and efficient, and at the same time astringent and antiseptic. It is used without apparatus, by dipping muslin or linen rags in the vinegar and carrying them into the uterine cavity by the hand. Several applications may be required. In desperate cases, where this remedy fails, which is scarcely deemed possible, resort should be had to the solution of persalts of iron, on the principle that dangerous conditions require desperate remedies.

The discussion was opened by Prof. WHITE, of Buffalo, who agreed with the author that uterine torpor was the general condition accompanying the bleeding, and that in the great majority of cases it could be prevented by proper management of the later stages of labour. He believed that while Dr. Wilson's expedient of introducing the hand may prove useful, it acted chiefly as a mechanical irritant or stimulant to the uterus. The only way to close the uterine sinuses is to secure firm contraction of the uterus. He uses acetic acid as a styptic, mopping the uterus with it, by means of absorbent cotton wound on a probe, to arrest hemorrhage after operations.

Dr. GAILLARD THOMAS believed that post-partum hemorrhage was always due to one of three causes: First, to want of power in the uterus itself, uterine atony or inertia; Second, the presence of some mechanical cause, such as uterine fibroid, retained clot or part of placenta, preventing the contraction of a willing uterus; Third, hemorrhage from solution of continuity or lacerations of tissue, or the rupture of a hæmatocele. He believed that in the great majority of cases uterine inertia is due to some neglect on the part of the attendant. A clot is allowed to collect after delivery and cause this condition. The physician should not leave his patient until he has secured the firm contraction of an empty uterus, he should always remain with his patient for one hour, and should stay twelve hours if necessary. Until this is done he should feel that the woman is in great danger. Throwing aside the binder as one of the superstitions of a past age, he should aim to accomplish complete uterine contraction. To do this, the safe practitioner will not rely upon any one remedy. In many cases any irritant applied to the inside of the uterus would be sufficient; dilute alcohol or hot water answers as well as sulphate of iron, the great danger of which will prevent it from ever coming into general use.

Dr. J. L. ATLEE recommended the introduction of the hand as a stimulant to the interior of the uterus, and it should be kept there until the uterus firmly contracts. Post-partum hemorrhage is often favoured by muscular weakness and want of exercise during gestation. In such cases ergot has proved very efficient as illustrated by the history of two patients.

Dr. ALBERT H. SMITH divides the cases into two classes, first, those arising from distension of the uterus; and secondly, those caused by laceration. The law of organization of the contractile tissue of the uterus makes it contract if it is empty. He was therefore pleased with Dr. Thomas's remarks that if we empty the uterus it will contract. Any manipulations or applications made will not be successful until the uterus is put into a condition to contract. A clot acts like a splint, keeping open the uterine sinuses and allowing them to bleed. A piece of retained placenta will also produce hemorrhage.

For the past two years he has been using injections of hot water of about 110° F., injecting the water at the same time that he turned out the clots. By this means there were less after-pains and less lochial discharge, and it was always followed by good results. The persalts of iron he considered a dangerous remedy.

Dr. **Engelmann**, of St. Louis, had not seen any bad results from mopping the surface of the uterus with solution of iron.

Dr. **Trask**, of Astoria, L. I., said that in such cases the iron acted as a stimulant, and not by virtue of its specific property as a styptic. The uterus generally contracts immediately on its introduction, but other agents are equally efficient and less dangerous. The injection of dilute tincture of iodine originated by Dr. Pirie, of Cuba, had proved in his hands always satisfactory.

Dr. **Chadwick**, of Boston, had used the iron in four cases, and thought that it induced septicæmia. Where this had occurred he found that permanganate of potassa injected into the uterus had been followed by recovery in three of the patients. The fourth, in whom the permanganate was not used, died of septic poisoning. In cases of inertia of the uterus he had found subcutaneous injections of ether to be promptly efficient.

Dr. **Barker** said that other causes existed for post-partum hemorrhage than had been referred to, and mentioned as one of these the hemorrhagic diathesis, which requires preventive measures during gestation. He referred to a case of this kind in which full doses of ergot were given, and constant pressure of the hand upon the abdomen was required for a period of six hours and a half. He would refer to two other causes of uterine hemorrhage than had been mentioned. First a class of cases where the fœtus is expelled so rapidly that the uterine fibres have not time to contract; and, secondly, the opposite condition where the labour is so prolonged that the uterus becomes exhausted. No procedure is so valuable as that described by Dr. Bozeman of placing one hand in the uterus and the other upon the abdomen and attempting to excite uterine contraction. And the hand should be allowed to remain until expelled by uterine contraction, as mentioned by Dr. Atlee. Some caution should be used, however, in introducing the hand. The cases are very rare where it will be necessary to practise this, except where there is partial adhesion of the placenta. He has seen injury resulting from the introduction of the hand into the uterus, and it should not be resorted to until other remedies have failed. He mentioned a case where the labour was neither severe nor protracted, but was followed by some hemorrhage. The physician introduced his hand into the uterus, and shock and continued loss of blood followed. He was called to see the case, and upon vaginal examination, detected a laceration of the cervical portion of the neck running up to the vaginal junction. Symptoms of septic poisoning set in on the second day, and she died in twenty-four hours.

In the *Annual Address by the President*, Dr. **William Goodell**, of Philadelphia, after paying a graceful tribute to the memories of Drs. Edmund R. Peaslee and W. L. Atlee, discussed the *Relation of Neurasthenia to the Diseases of the Womb.* In this able contribution great stress was laid upon the fact that local disorders of the uterus and ovaries are frequently merely the expression of constitutional states whose existence must not be overlooked.

Dr. **William H. Byford**, of Chicago, read a paper on *Dermoid Tumours of the Ovaries,* and gave the following as the theory of their development: "In the early period of ovulation or embryonic development, by some accident or modification of formation, indentation of the blastoderm is produced or somehow exists. In the wonderful developmental energy of that period, the minute depression is inclosed by the approximation of its blastodermic margin, and becomes an isolated cavity, and the growth and perfection of the embryo are accomplished, notwithstanding this early accident to the integrity of its envelope. The depression thus formed involves perhaps both layers of the blastodermic membrane, but the external layer becomes the lining membrane of the cavity, and is speedily cut off from the rest of the blastodermic surface, and invaginated with all its essential structures and processes of organization; all its organs, therefore, must be retained in the cavity. The contents of that cavity correspond in miniature with what the formation might have been if the displacement had not occurred. In the further development of the embryo the portion of the blastoderm covering this adventitious cavity develops its tissues and organs in the ordinary way, and thus incloses it in the body by the structures usually found to cover it. The internal layer of the blastoderm is doubtless also displaced, but it is not isolated, and, secondly, its products are never found inside of the tumour. Therefore, in instances where the dermoid patch occupies any of the mucous cavities the neoplasm will always be found external to the mucous membrane. This theory serves to explain why these hairy tumours are found in the fœtus, or the virgin, matron, and male, and with equal plausibility why they may exist in any part of the body."

Dr. **Noeggerath** described the mode of combination of the dermoid with the colloid or myxomatous tumour. Three varieties are observed. They are formed first by juxtaposition, one side of the tumour containing colloid elements, and the other dermoid. In another series of cases the characters are mixed throughout the cyst, making it partly caseous and partly adenomatous. There is a third class of tumours where a large serous cyst forms in the dermoid tumour itself by retained secretion of the sudorific glands.

By the term inclusion, which Dr. Byford has used, we mean at the present day not any inclusion of a part of a second fœtus. We know that the genital organs are developed from the axis cylinder; and, secondly, from the primordial vertebra. In the formation of the Wolffian body in the process of the development of its parts, we find at some point adhesion may occur between the epiblast and the mesoderm, thus including some of the cells of the epiderm, and accounting for their presence in the ovary according to Waldeyer's theory. At the time of puberty this is apt to take on rapid development from the special *nidus formativus* existing in the ovary itself. Thus epithelial cells are found among the stroma, explaining the presence of these tumours in the virgin. The same theory explains their presence in other parts of the body.

Dr. W. L. **Richardson**, of Boston, presented *A Contribution to the Study of the Treatment of the Acute Parenchymatous Nephritis of Pregnancy*, in which he stated that albuminuria occurs in 42 per cent. of pregnant women, and is not so rare nor so dangerous a combination as supposed. In 26 cases occurring in his own practice, convulsions appeared in 14. The decrease in the quantity of urine in such cases is always a signal of danger. He recommends the systematic examination of the urine of pregnant women even when no trouble is suspected; and, secondly, when we find albuminuria, the urine must be measured daily, and whenever we find it falling below the average, must endeavour, by general means, to increase it. If this is unsuccessful, we should induce labour, which becomes more imperative when the pregnancy has reached that period when the fœtus is viable.

Dr. **Gaillard Thomas** fully endorsed the paper. In an obstetrical experience, extending over a period of twenty-seven years, he could recall only two cases where the puerperal convulsions were not attended by albuminuria; and in one of these a small amount of albumen was subsequently detected, the renal secretion not having been examined previously. He did not mean to say that the albuminuria caused the convulsion, but that it accompanied it. In such cases, where stertorous respiration at night occurs—a most important symptom — where amaurosis appears, and the secretion of urine becomes deficient, the fluid becomes three-fourths solid by heat and nitric acid, nothing will relieve the symptoms but the induction of premature labour; but other means must be previously tried, as pointed out recently by Dr. Barker, and referred to by the author of the paper. Pilocarpin promises to be a valuable remedy. According to his experience in the great majority of these cases, medicines will almost invariably fail, and labour must be induced. He could not recall a single case in which he had induced labour for these convulsions where he had regretted it.

Dr. **John L. Atlee** said that he had followed the teachings of Dr. Dewees, and used the lancet, and he had yet to lose his first case.

Dr. **Fordyce Barker** said that his experience would not warrant him in going to the extent Dr. Thomas had in placing such exclusive reliance upon the condition of albuminuria. He had reported a number of cases where this condition was not found, although it is almost always an accompaniment. Nor did his experience agree with that of Dr. Tyler Smith as regards the general results of treatment. He believed very strongly in medical treatment, but he also believed that premature labour should be brought on where there are symptoms indicating danger to the mother or the child. One of the most striking symptoms is the presence of albuminuria; if it persists, and dangerous symptoms appear, labour should be induced. He agreed with Dr. Atlee as to the value of bloodletting in obstetric practice as prophylactic against convulsions, and as a protective against the consequences of blood-poisoning by defective renal secretion. It removes part of the poisonous material, and supplements the action of the kidneys. Lives have been saved by it. The great remedial result from bloodletting is in saving the system from the effects of the convulsions.

Dr. **George H. Lyman**, of Boston, said that in addition to the cause mentioned, which was a frequent one, the eclampsia may be due to hysteria and to epileptic convulsions following delivery.

Third Day.—The following report was received from the Nominating Committee, and adopted: Officers for 1879: President, T. Gaillard Thomas, M.D., of New York; Vice-Presidents, Drs. D. H. Storer, of Boston, H. P. C. Wilson, of Baltimore. Council, Drs. T. A. Emmet, of New York, Albert H. Smith, of Philadelphia, John Byrne, of Brooklyn, George J. Engelmann, of St. Louis. Secretary, J. R. Chadwick, M.D, of Boston. Treasurer, P. F. Mundé, M.D., of New York. Honorary Fellows, Drs. J. S. Billings, U. S. A., and J. Matthews Duncan, of London. Fellow, Nathan Bozeman, M.D., of New York.

Next place of meeting, Baltimore; time, third Wednesday in September, 1879.

Alternating Anterior and Posterior Version of the Uterus, was illustrated by Dr. S. C. **Busey**, of Washington, D. C., by a case in which this condition was apparently brought about by an elongated and cartilaginous cervix. The uterus being bound down by tension of the lower part of the left broad ligament was forced into these changing relations, by alternating conditions of rectal and vesical distension or collapse.

The next paper was on *Gastro-Elytrotomy,* by Dr. H. J. **Garrigues**, of Brooklyn. The history of the operation was reviewed, and its results contrasted with those of Cæsarean section. Baudelocque's is the only case in which the operation was performed prior to that of Dr. Thomas. Passing over the discussion of the dangers and the details of the operations of Cæsarean section, and its comparative mortality, he observed that of all the cases of Cæsarean section performed in New York City for the last two hundred and fifty years, only one was successful. Indeed authors claim only from 54 to 62 per cent. of recoveries. Dr. Thomas originated the operation anew, and proved its practicability by dissections, before he performed it in a living woman. Dr. Skene, of Brooklyn, has also performed it with success. The operation has been performed five times in all; four of the children were saved, and three of the mothers are still living.

The chief danger in the operation appears to be in the hemorrhage from the vaginal wall. To obviate this Dr. Thomas makes a small opening sufficient to introduce two fingers, and then tears it up and down to the desired extent. The author recommended the primary opening to be made by the galvano-cautery, subsequently enlarged by the fingers, in a transverse direction, or parallel with the brim of the pelvis.

In reviewing the steps gone through in originating the operation, Dr. GAILLARD THOMAS said that in his case it would certainly seem that "when ignorance is bliss 'tis folly to be wise," for if he had known of the unfortunate cases reported by Ritgen and Baudelocque, he never would have had the courage to perform the operation upon the living subject, and indeed had his first operation been unfortunate, he should have felt like a distinguished surgeon at his first ovariotomy, many years ago, who declared that if it had proved unsuccessful he never would have repeated it.

A woman, in the ninth month of pregnancy, having died with convulsions, he had the opportunity of demonstrating upon the cadaver the value of the operation, which he then believed to be new. Dr. Noeggerath told him that he had read of it before, and subsequently referred him to the cases of Baudelocque and Ritgen; but not before he had successfully repeated the operation upon a living woman. If in Baudelocque's place, he would have been ashamed to publish the two cases in which he opened the iliac artery, as they are not creditable to his skill. He once saw an operation for ovariotomy where the operator cut directly into the bladder without recognizing it, and coolly dissected it off from the tumour to which it was adherent; the woman died upon the operating table. A skilful ovariotomist would never have made this mistake. So in performing this operation he never even saw the external iliac artery, and would have had to go out of his way to expose it. But even if it should be wounded there is nothing to prevent a ligature being thrown around it or even from proceeding to tie the common iliac if necessary. There is a large opening to work in, and hemorrhage is overcome as easily as in other surgical procedures. To avoid hemorrhage after the operation, the vagina can be packed with a tampon of carbolized cotton, another plug being packed into the iliac fossa, a bandage carried tightly around the waist will now press the two tampons together, and make firm compression, should any tendency to bleeding be observed. No bleeding can persist. The tampons should remain not longer than twenty-four hours. He would have used this in the last case had hemorrhage followed the operation.

The question for operators to decide is, which is the safer for the mother and the child, this operation or the Cæsarean section? It is universally acknowledged that Cæsarean section is the most dangerous operation of surgery. Gastro-elytrotomy has been performed only five times on living women, one of whom was moribund at the time of the operation, which was performed to save the child under the following circumstances: The family were exceedingly anxious that the child should be born alive, so that it might be baptized. The question was, in what way can you deliver this fœtus from this practically dead woman with more safety, by version or Cæsarean section? He compromised, and performed gastro-elytrotomy, and saved the child. He preserved the only living one of his two patients. He then referred to a case of Dr. Skene. In this instance the fœtus was dead. In this case the mother's life was saved. His last operation was under particularly unfavourable circumstances, and it should be remembered that this operation has not been performed upon selected and favourable cases. It is claimed that Cæsarean section is not resorted to until the cases are given up, and other procedures are hopeless, but it must not be concluded, *per contra*, that gastro-elytrotomy is performed upon exceptionally favourable cases. This operation offers a choice where gastro-hysterotomy is otherwise indicated. In the last operation, the patient had been for some time, sixteen or eighteen hours, in labour when natural delivery was found impossible. She was then put in a carriage, and driven from the town of Harlem to New York, and was placed in a lying-in hospital, which had all the faults of its class, and had been exposed to septic influences for years. The problem was, should we perform

Cæsarean section or craniotomy? At the consultation he recommended gastro-elytrotomy, and he performed the operation. The child was safely delivered. The mother was perfectly well at the end of three weeks. Recovery was delayed by severe chills, which were probably not septicæmic, as they were controlled by quinia, and she came from a malarial neighbourhood.

No especial difficulty attended the operation. After making the incision in the median line, as in Cæsarean section, avoiding the peritoneal cavity, the peritoneum was carefully peeled off on the right-hand side, and the wall of the vagina dissected from its attachment to the extent of two and a half to three inches. A small opening was then made, sufficient to introduce two fingers, and the vagina torn both upward and downward. In the delivery of the child this opening becomes stellate, and the right wall of the vagina annihilated.

Dr. Thomas asked, Why is it that in the last two hundred and fifty years, in all the operations by Cæsarean section that have been performed in the city of New York, there has been but a single successful case, while in the same city in the last eight years, out of five cases of gastro-elytrotomy there were three recoveries? This cannot be accidental. In one of the cases reported by Dr. Skene, the condition was so desperate, and the results of the operation so marked that it reads like a romance, and he could scarcely believe it had it not been given on such good authority.

The danger of wounding the bladder, which has been referred to, is not of great importance. We know that in the modern operation of making an artificial opening into the bladder for the relief of cystitis, the great difficulty is in keeping the wound from healing, and we have to resort to the actual cautery to keep it open. If the bladder should be accidentally cut in the operation, which need not happen in the hands of a skilful surgeon, it will heal of itself; it requires absolutely no treatment. In regard to cellulitis, he thought that with antiseptic precautions it may be avoided. It is not necessarily the result of the operation.

Dr. **Byford** thought the chief advantages of the operation are that it gives a free outlet to the fluids, the peritoneal cavity is not opened, the body of the uterus is not wounded, and finally the operation does not interfere with the subsequent performance of Cæsarean section. It could be performed, he thought, as successfully as ovariotomy, were it not for the fact that it is done during pregnancy, when the pelvic viscera are in a state of exaggerated nervous and vascular supply. From what he had heard he would favour the operation. Peeling off the peritoneum is not more dangerous than when undertaken for tying the common iliac artery, when it is not considered of special importance.

Dr. **Bozeman**, of New York, said that a surgical objection to the operation would consist in the fact that as the ureters course along the side of the vagina they must be ruptured in this operation and uretero-vaginal fistula result. This he thought had occurred in those cases where it was supposed the bladder had been opened. In the successful cases, the continuity of the ureter must have been restored in the process of healing. The danger of this complication will be inferred from the fact that only one case is known to surgery where rupture of the ureter has been followed by recovery.

Dr. **Garrigues** advocated a horizontal or oblique rupture of the vagina instead of the longitudinal one proposed by Dr. Thomas, since the greatest vascularity of the vagina is near its two extremities.

Dr. **Thomas**, in reply to Dr. Bozeman, said that in his first operation he was afraid of wounding the ureter and searched for it, but did not carry his dissection far enough to encounter it. He did not think that it was necessary to expose it. The fact that there is on record but one case of recovery after rupture of the ureter he thought was sufficient proof that this accident had not occurred in his successful cases.

In a paper on *Pendulum Leverage of the Forceps* Dr. **Albert** H. **Smith**, of Philada., particularly discussed the advantages of direct traction over the pendulum movement in delivering the head where there was delay in the second stage of labour, and he presented the following conclusions:—

1. That pendulum movements are in direct violation of the teachings of nature.

2. That they are absolutely useless as far as aiding traction is concerned.

3. That any virtue they have is by stimulating uterine action which then operates entirely independent of them.

4. That so far from diminishing friction, they increase the mutual pressure of the head and pelvic walls, thus increasing friction.

5. That they tend to do injury to the pelvic tissues no matter at what point of the pelvis they are practised.

6. That so far from being specially useful when the head is "tightly gripped," to use Dr. Galabin's expression, and the extraction difficult; the greater the difficulty of the case, the greater necessarily is the injury to the tissues.

7. That so far from economizing force they waste it.

Dr. **Jas. P. White** said that the forceps in shortening the second stage of labour, often prevent the injurious effects of delay upon the maternal tissues, and enables us to save the lives of children that would otherwise perish. Its powers are said to be three—traction, compression, and the lever movement. In regard to the traction, little need be said beyond the fact that it should be in the line of descent, and applied during the pains. The child's skull is compressible to a considerable degree, under the pressure of the forceps; its bi-parietal diameter decreased and its long occipito-mental diameter is increased. This compression, however, should not be applied continuously as, by interfering with the circulation of blood in the brain, it would slaughter the child. Between each pain the head recedes and the circulation goes on. This power of compressing the head is of considerable importance in accomplishing delivery. In regard to the lever movement, he believed that those who advocated and recommended it most strongly did not use it nearly so much as their writings would lead us to infer. Some authors would make us believe that we must depend mainly upon lateral movement and rotation, which is absurd. But where there is delay in the early part of the descent of the head, a gentle movement of the handles towards the left iliac region, if the head is in the first occipito-anterior position, and then posteriorly and to the right, will often give it a start that is of great assistance; but it should never be a prominent aid to delivery. While traction is our chief reliance, sometimes gentle motion may be made with benefit. In regard to the lateral movement, no hard rules can be laid down, while the operator must be perfectly familiar with the anatomy of the pelvis and its relations to the descending head, he must be guided by good judgment.

Dr. **Fordyce Barker** was glad to discuss a paper so full of suggestive points as this valuable contribution, but he could not do justice to all the points in the short time allotted. He would first review the ground to see in what points he could agree with the author, and then take up those wherein they differed. The forceps are first a valuable instrument of traction, and secondly of compression. Now in what direction is the traction to be made? In that of the canal where the head happens to be. So far we are agreed. We also agree that it is an instrument of great value where any difficulty exists interfering with the progress of the mechanism of labour. In those cases where the occiput fails to rotate under the symphysis pubis, he supposed Dr. Smith would allow a pendulum motion to encourage the head to complete the rotation. Now, wherein do we differ? The author believes that the traction should always be made in a direct line, wherever the head should happen to be, at any point in its course from the entrance of the cavity to the outlet. He believes we should never carry one extremity of the bi-parietal diameter faster than the other. In the diagram a fallacy is noticed which runs through the author's argument, that the centre of the bi-parietal diameter is a fixed point, and that if one side of the head advances the other must proportionately recede. This centre is not a fixed point. He would advocate moving both sides of the head, but one more rapidly than the other. This is a question of physical law and not a process of reasoning. Placing his knife transversely between his fingers, he assumed that the knife represented the transverse diameter of the head and his finger and thumb the soft parts contained in the pelvic cavity. Now by what process would the tissues receive the least friction by advancing both ends equally or by moving one side a little more rapidly than the other? The great objection that Dr. Smith would urge is the danger to the soft parts of the pelvis by the lateral motion; but it is seen by this illustration that the injury to the soft parts is less. If we represent the amount of friction on the side of greatest motion by the number 10, the amount on the opposite side moving half as fast would be 5 and the danger would be reduced 25 per cent. There is an additional advantage in the fact that alternately each part would have a period of rest. He did not wish to be understood as advocating extreme motion, nor should he ever think when one side is advancing of allowing the other to recede.

Dr. D. H. Storer desired to mention a case showing the evil effects of compression of the skull by the forceps. A gentleman had deep furrows over the parietal bones, which were produced at his birth by the forceps. The patient was eccentric, and almost idiotic, and died at an early age. He wished to impress the fact that too great pressure upon the head may destroy the man.

Dr. Penrose advocated the Philadelphia treatment as laid down by the late Hugh L. Hodge, that ordinarily only sufficient pressure should be applied to make the head and the forceps one body, but, under certain circumstances, they may be used as compressors. As levers, they should only be used to assist their action as tractors; or in a general way only to dislodge the head when it ceases to recede. By this method he has delivered children that could not have been delivered alive by any other means.

Dr. Gaillard Thomas said that, in addition to the powers of the forceps that had been enumerated, he was in the habit of classing them as rotators. And this, he thought, was the explanation of the misunderstanding between the author and Dr. Barker. He confined his remarks to considering the lever movement by itself. Is it best to deliver a head directly by traction or by resorting to the pendulum movement? Early in the course of labour this is not necessary, but where the second stage is prolonged, the head remaining in the pelvis for four or five hours, interfering with the return of venous blood from the parts below, the tissues forming an œdematous ring beneath the head, then a slight lateral motion, forcing out the serum from the swollen tissues, is of great value, and is perfectly legitimate. The latter movement should be slight and not of an exaggerated swaying character.

Dr. Goodell considered the subject as a many-sided one, and he was in accord with the teachings of Dr. Smith in gross, but differed with him in certain particulars. In regard to the lever movement we must ask first, Is it an injury to the mother's tissue, and secondly, is it a mechanical advantage to delivery?

Compression moulds the head to the cavity, and accommodates it to the pelvic inequalities. It can be delivered by lateral motion alone without the aid of traction from the forceps. The head is never moulded exactly to the pelvis, and the forceps are never applied exactly over the parietal bones. Moreover, no pelvis can be found which is perfectly symmetrical. In regard to the safety of the mother, it must be confessed that injury may be accomplished by lateral motion, and it is a very rare thing for him to use it. The danger increases as the head descends into the lower portion of the pelvic canal. As an aid to delivery, if the head be moved the friction is less than by steady traction, and it causes the head to accommodate itself to the canal by a change of shape.

In his view of the forceps as a mechanical aid, Dr. Smith was sorry to stand alone, but was not convinced of his error. If the object is to compress the head by lateral motion, why not use the forceps directly for that purpose, and save the mother's tissues? The forceps are to be used with just enough compression to take off the friction of the head from the soft parts. He thought that Dr. Barker and Dr. Thomas had both overlooked the fact that the fœtal head is not shaped like a knife, but is an ovoid body. He, therefore, could not admit the force of the simile. In regard to Dr. Thomas's case, where the puckered-up tissues are in advance of the head, shall we not produce less danger to these tissues if we make traction directly downward in the line of least resistance? And if by a swaying movement we condense the tissues already congested and bruised, in the end we dilate just as much. As a general rule, the forceps should not be used as rotators; but neither should they resist rotation. We should allow the forceps to rotate with the head in obedience to the mechanical law of the pelvis, just as the German school believe in allowing the head to rotate in the grasp of the forceps; but he could see no analogy between allowing the forceps to follow the head, and the backward and forward and swaying movements that have been recommended. Every one who has spoken terms this a dangerous method, but all seem to want a little of it. They do not recommend this procedure in simple cases but only in difficult ones. But the more difficult the case, the more tightly the head is held in the pelvis; the more that simple traction seems likely to fail, the more danger there is in the lever movement. From his own experience he knew that he could deliver the child with vastly less force with slight compression with direct traction than he could with leverage combined with traction.

In searching for illustrations, we must remember that the head is fixed by resistance from surrounding parts, and not by any fixed point. This must be overcome by taking off the pressure of the head from the tissues by slight compression. In traction there should be no deviation from the line of the pelvic canal, as was recently taught by Tarnier. If two-thirds of the force be lost in pressing the head against the side of the pelvis, as recommended by Bedford, only one-third of the force is available for the delivery.

Dr. HENRY F CAMPBELL, of Augusta, Georgia, read a paper on *Rectal Alimentation in the Nausea and Inanition of Pregnancy*, illustrated by a case where for fifty-two days no other mode of feeding was employed. One half pint of beef essence was injected twice daily. The enemata were retained, and apparently passed through the ileo-cœcal valve into the small intestine. The nutrition of the patient was sustained; she aborted, was delivered of a still-born child, and made an excellent recovery. Ulceration of the cervix uteri was discovered early in the history of the case, which resisted treatment. In order to determine whether enemata could pass into the small intestine, Dr. Campbell made an experiment upon a kid, to which he gave nutritious enemata stained with some colouring matter; the animal was killed on the eighteenth day, and the coloured material was found throughout the small intestine as far as the fourth stomach. For this retro-peristalsis Dr. Campbell proposed the name of Intestinal Inhaustion.

Dr. JAS. P. WHITE offered the notes of a case of *Punctured Wound of the Rectum*, which were not read, owing to the arrival of the hour of adjournment.

On motion of Dr. White a resolution was unanimously adopted, thanking Dr. Chadwick for his valuable, arduous, and otherwise unrequited labor in performing the duties of Secretary of the Society, and superintending the publication of its Transactions.

On motion of Dr. Barker, a vote of thanks was tendered Dr. Goodell for the ability and faithfulness with which he had performed the duties of presiding officer of the meeting.

Dr. Goodell said that in bringing the session to a close he congratulated the Fellows upon the high position which the Society had taken, the eagerness with which its membership is sought, and the active demand for copies of its Transactions.

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The different nervous diseases are taken up systematically and fully treated The volume throughout is written in clear and practical language, and contains in brief the salient points of clinical history, diagnosis, pathology, and treatment of nervous diseases recognized at the present day. The work has been prepared with a view of meeting the wants of the student and general practitioner. Whenever necessary, handsome illustrations are added to explain the text. It is a volume which will supply a need long felt by the profession, and to Dr. Hamilton the profession is indebted for this clear and able classification of nervous diseases and a publication of uncommon merit.—*Md. Medical Journal*, Aug. 1878.

The treatment is up to the requirements of the most advanced therapeutical and pathological knowledge. The work is free from dogmatism, and as a whole may be accepted as containing about the best information on the subjects within its scope, compressible within so limited space. It is lucid and direct in style, and the author certainly has succeeded in his purpose, as announced in the preface, of producing a "concise and practical book."—*Cincinnati Lancet and Clinic*, July 20, 1878.

In the modest preface to his work, Dr. Hamilton expresses the wish that he may have made the diagnosis and treatment of nervous diseases more simple. We believe he has succeeded in this in an eminent degree. His book is a safe guide for the general practitioner, and an excellent text-book for the student, inferior to none that we know of, and vastly superior to some that we forbear to name.—*Ohio Med. Recorder*, Aug. 1878.

As stated in the preface, the author's object has been to write a concise and practical book, for which there is certainly a place, and we think he has succeeded admirably in fulfilling his object. The usual plan is adopted in the classification of the different diseases, the book being not greatly unlike Hammond's in this respect, although it is very noticeable throughout that the author's opinions vary widely from those of Dr. Hammond —*Am. Supp. Obstet. Journ. Gt. Britain and Ireland*, July, 1878.

A wide acquaintance with the recent literature of nervous disease is manifested throughout, and an attempt—and a successful one—is made, to do away with much of the obscurity and confusion arising from physiological themes, which cloud several of the more popular recent works on the same subject.—*Med. and Surg. Reporter*, July 6, 1878.

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The scope of this useful and somewhat novel work can best be understood by the subjoined condensed

SUMMARY OF CONTENTS.

CHAPTER I. The Physiognomy of Disease. II. Examination and Reporting of Medical Cases. III. Temperature—Pulse—General Signs of Pyæmia. IV. Skin—Hair—Nails—Glands—Joints. V. Examination of the Organs of Special Sense. Subjective Disorders of the Special Senses—Testing of Cranial Nerves. VI. Symptoms of Disorder in the Nervous System. VII. The Use of Electrical Instruments. VIII. Insanity. IX. Disorders of the Respiratory and Circulatory Systems. X. Examination of the Fauces, Larynx, and Nares. XI. Disorders of the Digestive System. XII. Jaundice and Dropsy. XIII. Examination of the Urine and Significance of Urinary Symptoms. XIV. Symptoms connected with the Male Generative Organs. XV. Disorders of the Female Organs and their Relations to the General Health. XVI. Physical Examination of Chest and Abdomen—Lungs—Heart—Abdomen. XVII. Method of performing Post Mortem Examinations.

The different chapters have been contributed by gentlemen specially versed in their several subjects, including, besides Dr. Finlayson, Professors Gairdner, William Stephenson, Sansom Gemmell, and Drs. Alex. Robertson and Joseph Coates.

HENRY C. LEA—Philadelphia.

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VOL. XXXVI. NOVEMBER, 1878. No. 431.

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CLINICAL LECTURES.

A CLINICAL LECTURE ON THE TREATMENT OF PARALYSIS FOLLOWING DIPHTHERIA.

By N. S. DAVIS, A.M., M.D., LL.D.,
Physician to the Mercy Hospital, Chicago.

Gentlemen: You will recognize the patient before you as one to whom your attention was called briefly two weeks since (Jan. 4th), just after his admission to the hospital. He is a young man, aged 19 years, born in this State, resident of an interior town, and by occupation a farmer. He is physically well developed, and previous to the first of October last had enjoyed good health. In the early part of that month he was attacked with diphtheria, which affected his fauces, glands of the neck, and Schneiderian membrane severely for two weeks, after which he recovered so fully that he commenced doing some work during the second week in November, although his voice was weak and somewhat nasal. About the middle of November, after having been exposed to cold while husking corn in the field, he had complete loss of voice, and almost entire loss of vision, with general muscular weakness. In about two weeks he had recovered his voice and vision, though not perfectly, for even up to the time of his admission into the hospital, on the 3d of January, his pupils were larger than natural, and small objects appeared dim or indistinct. But when his voice and vision had nearly recovered, the weakness of his lower extremities began to increase, and

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

☞ *In no case is this periodical sent unless the subscription is paid in advance.*

by the middle of December he was unable to walk, or even stand on his feet without support. This continued until he was brought to the hospital, it having been necessary for assistants to carry him from his room to the carriage when he left home. At the time of his admission here, you will remember that his look was moderately anæmic; expression of countenance sad; pupils of the eyes large and responding to changes of light less readily than natural; tongue clean; pulse 90 per minute and soft; skin soft, and temperature 36.5° cent.; digestive organs apparently healthy, and secretions natural. His speech and deglutition appeared good; slight dimness of vision; occasional feeling of numbness in the fingers, but the use of the muscles of the arms and trunk of the body apparently unimpaired; but his lower extremities were still so far paralyzed that he could stand, or attempt to walk, only by the aid of assistants supporting him. He suffered no pain, and but slight alterations of sensibility anywhere.

I have thus recalled your attention to the history and principal symptoms of this case, not only for the purpose of enabling you to appreciate more clearly the progress of the patient during the two weeks since his admission here, but also for the aid it will give us in considering more fully the pathology and treatment of the class of cases to which this belongs. That the form of paralysis represented by the case before you, frequently follows as the sequel of diphtheria, is well known. In a large majority of the cases the paralysis is limited to the muscles of the fauces, causing more or less difficulty of speech and deglutition. In the slighter attacks the only marked symptoms will be unnatural slowness of speech, with a decided nasal sound to the voice, and passing of the food and drink into the posterior nares, and sometimes into the larynx unless special care is exercised in swallowing. In severer cases there is more complete aphonia, and more rarely entire suspension of deglutition. During the prevalence of an epidemic of diphtheria in this city many years since I was called in consultation to a case of this kind. The patient, a boy, aged ten years, after convalescing from an attack of the diphtheria of ordinary severity, in eight or nine days began to exhibit signs of partial paralysis of the muscles of the fauces and adjacent parts. These evidences of paralysis increased until voice and deglutition were both entirely suspended; and for more than two weeks he was nourished solely by introducing milk and other nutriment into the stomach through a stomach-tube.

Next in frequency to the muscles of the fauces and pharynx we find those of the eye affected with paralysis, generally causing dilatation of the pupil and such imperfect adjustment, as to impair or suspend vision. The muscles of the upper and lower extremities suffer next in frequency; and in some patients, like the one before you, these several parts are attacked in succession, somewhat resembling the migrating character of articular rheumatism. In the great majority of cases this form of paralysis is limited to the muscles of voluntary motion, but in some cases it has extended to those of respiration and circulation, thereby impairing these functions to such a degree as to cause the death of the patient. Death may result directly, from the inability of the respiratory muscles to perform the mechanical work of respiration, or from paralysis of the heart; but in a larger number of cases death is reached, indirectly, from the passage of particles of food or drink into the larynx and bronchial tubes, inducing either suffocation or fatal broncho-pneumonia.

Oertel states the ratio of deaths in paralysis following diphtheria to be from eight to ten per cent. Of seventy-seven cases collected by Dr. Reynolds nine proved fatal. If I were to be guided by my own observation I should say that the prognosis was, in all recent cases, favourable. During the twenty-nine years that I have practised in this city several marked epidemics of diphtheria have prevailed in the community, and in each, cases of paralysis as sequalæ of the acute disease, of varying degrees of severity, came under my care, but up to this date I have not seen a case that terminated fatally, either in the hospital or in private practice. In most of the cases, the first indications of paralytic trouble were observable in from one to two weeks after the disappearance of the entire symptoms of diphtheria. But in some instances they were not manifest until two or three months after convalescence from the original disease. The paralytic symptoms are generally slight at first, and increase in severity during the first week, remain about stationary a few days, and then decline. When it is manifested in only one set of muscles, it often disappears in from two to three weeks. When it affects the muscles of different parts in succession, the trouble may be protracted through several months.

Concerning the nature or special pathology of this form of paralysis, medical writers give us but little information. Most of them regard the diphtheria as caused by a specific poison, capable of not only developing local inflammatory action with a peculiar membranous exudation, but also effecting changes in the blood and all the phenomena of a general disease. Probably a large majority of English and American physicians regard the poison as acting primarily on the blood and properties of the tissues, developing a primary general disease, and secondary local inflammations in the fauces, glands of the neck, etc.; while Oertel, Buhl, and others regard the essential cause as a species of organic germ, called *micrococcus*, which first impinges on the surface of the mucous membrane of the fauces, or other parts of the body, and induces primarily a specific local inflammation and exudation, in which the germs are greatly multiplied, and from which they penetrate the tissues and the blood in such numbers as to cause secondary general disturbance of more or less severity. (See chapter on diphtheria, in Ziemssen's *Cyclopedia of Practical Medicine*, vol. i.)

But during the last few years, microscopists have so generally found some variety of organic germs present in the blood, and morbid products of almost every disease, that we may very properly doubt whether they are not *consequences* of any and all morbid processes of a degenerative character, instead of causes. My own microscopic studies have given me a strong inclination to regard this latter view as correct. Notwithstanding the diversity of views entertained by writers in regard to the nature of the essential cause or causes of diphtheria, nearly all agree that the paralysis, sometimes following it, results from the *toxæmic* effect of the poison on the nervous and muscular structures of the paralyzed parts. A few, looking to such cases as involve only the muscles of the fauces and pharynx, have attributed the loss or weakness of the muscular action to the direct effects of the local diphtheritic inflammation on the nerves of the part. If this view were correct, the paralysis ought to be somewhat in proportion to the severity of the preceding inflammation, and should be limited entirely to the muscles of such parts as had been inflamed, neither of which is found to be in accordance with the well-known clinical facts. On the contrary, cases of paralysis of a severe character have followed very mild attacks of diphtheria, and so far from being limited to the parts involved in the local inflammation, it may affect the muscles of any part of the body and extremities as you see in the patient before you. Without detaining you with a further allusion to the opinions of writers, I will simply state the results of my own studies and clinical experience. That diphtheria is a general febrile disease, produced by a cause or causes, that act primarily upon the blood and properties of the tissues, indicated by general disturbance of the functions of the system, and subsequently developing special local inflammations, I have no doubt. To a careful and experienced observer the order of sequence, in the development of symptoms and morbid changes, is too plain to be mistaken. In this respect the local inflammations and diphtheritic exudations bear the same relation to the general disease that the inflammations in the fauces and glands of the neck do in scarlet fever, and the morbid changes in the glands of the ilium and mesentery in typhoid fever. To understand clearly my views of the *modus* *operandi* of the causes of diphtheria, and of the pathology of the paralytic affections following it, you must keep in mind the fact that all organized living matter possesses two elementary properties, namely, a susceptibility or capability of receiving an impression, and an affinity which regulates the movements of atoms caused by the impressions made.

It is this elementary property, which I call susceptibility, that enables the muscular fibre to respond to the electric current or the nervous force; the secreting cell to the presence of arterial blood; each organic cell or atom to the presence of the proper material for its own nourishment; and the nerve cell or fibre to the presence of its appropriate excitant; while the special elementary affinity guides the movement of each atom to its appropriate place in the processes of nutrition, disintegration, secretion, etc. Hence, so long as the various living structures possess these properties in their natural degree, and are supplied with blood natural in quantity, in the relative proportion and quality of its constituents; free from extraneous toxæmic or hurtful ingredients, and moving in the natural degree of velocity, all the resulting actions or processes will be natural, and what we call health will be preserved. But if any one of these conditions fail or become notably altered in any direction, morbid or unnatural results necessarily follow.

In diphtheria it is evident that the blood has either imbibed a specific morbid material, or undergone some change in the quality of its constituents (most likely the former), by which it makes a decidedly unnatural impression upon the properties of the tissues, impairing the sensibility of the vaso-motor nerves, and thereby altering the movement of blood in the capillary vascular system, perverting the play of vital affinity by which secretion and nutrition are disturbed and generally retarded, and giving rise to those appreciable symptoms of general disturbance that are presented in the first stage of the disease.

The nature of the morbid material or change in the blood is such that it not only disturbs the elementary properties and functions of the system generally, but it exerts a special irritative influence on the mucous membrane of the fauces, and sometimes other parts, creating in them an inflammation of an asthenic or aplastic character, as shown by the persistent tendency of all its products to degeneration, whether in the form of membranous exudations upon the surface, or into the parenchyma of the glandular and areolar structures.

This view is fully corroborated by the microscopic observations, as detailed by Oertel and others, showing not only the early appearance and great abundance of organic germs in the form of micrococci, bacteria, etc., but the coincident presence of pus corpuscles and other products of retrograde metamorphosis, both in the exudations upon inflamed mucous membranes and in the parenchyma of inflamed structures.

And even without the aid of the microscope, the same aplastic and degenerative character of the morbid processes in diphtheria are abundantly shown by the early breaking up and disappearance of the membranous exudations; the offensive odour; the ready establishment of ulcerations and gangrene; and the general weakness of the muscular system. The last-mentioned condition is particularly noticeable, both during the progress of the disease and through the convalescence, and quite as much in the heart and muscles for involuntary motion, as in those under the control of the will. All these circumstances show that there is something in the nature of the morbid actions constituting this disease, that leaves the properties of the nervous and muscular structures more impaired than after most of the other acute febrile affections; and hence in a condition highly favourable for the supervention of paralysis at any time during the convalescence. In studying the nature of the paralysis itself, you must remember that impairment and loss of muscular power in any particular muscle or set of muscles may be caused by either of the following morbid conditions: 1st. Disease in the central part of the nervous system involving the origin of the nerves supplying the paralyzed part. 2d. Disease of some part of the nervous cord between the centre from which it emanates and its peripheral distribution. 3d. Disease of the peripheral extremity of the nerves in the paralyzed part. And 4th. Loss of susceptibility, or what Haller called *irritability*, in the muscular structure itself. The condition last named is deserving of more attention than it has received from most of those who have given special attention to the study of paralytic affections.

The members of our profession have come to look so directly to the nervous structures for an explanation of all changes in sensibility and motor power, that the existence of a property or susceptibility inherent in muscular or any other structures, by which it is capable of being impressed or acted upon by exterior influences has been apparently overlooked. Yet no physiological fact is more easily demonstrated than that such a property exists, not only in the atoms constituting muscular, but also those of all other living structures. Indeed without such a susceptibility in the muscular structures, no amount of nerve-force or intensity of electric currents would elicit the slightest muscular action or motion. This property can be impaired or suspended, by retarding or arresting the supply of arterial blood, by retarding or suspending the molecular changes constituting nutrition and disintegration, and by contact with certain toxæmic agents, such as carbonic and hydrocyanic acids and other sedative poisons. If, while keeping these physiological facts in mind, we return to the study of the morbid phenomena preceding and accompanying the existence of diphtheritic paralysis, we shall be compelled to look to the muscular structures involved rather than to any part of the nervous centres for the essential seat of the disease.

The decidedly asthenic character of the primary disease; the aplastic and degenerative quality of all its morbid products and changes, leaving the processes of nutrition and metamorphosis enfeebled during the convalescence; the gradual manner in which the paralysis supervenes; the coincident impairment of the electro-excitability of the affected muscles; the tendency to affect the muscles of different parts of the system in succession, those of one part recovering, while those of another are increasing, while the nerves supplying the muscles thus successively attacked have no common or closely approximative origin in the cerebro-spinal centres; and the absence generally of all direct symptoms of cerebral or spinal disease coincident with the failure of muscular action, all point, in my estimation, to an impairment or loss of susceptibility and contractility in the muscular structures involved. This impairment of the primary property and function of the muscular structures may depend on an inadequate supply of arterial blood through feebleness of the capillary circulation in the part; or on the toxæmic influence of the products of the retrograde metamorphosis of such exudations as had taken place in the structures during the progress of the primary diphtheritic disease, or on both combined. I might sustain these views by other facts, particularly those derived from microscopic examinations of the nervous and muscular structures in cases terminating fatally, as described by Oertel, Buhl, and others, but the clinic hour is too far advanced, and I must hasten to a review of the treatment. If the foregoing views are correct, the principles that should govern us in the management of this variety of paralysis are obvious and capable of being stated in a few words. First as a means of preventing the supervention of paralysis, patients during convalescence from diphtheria should be very careful in the taking of exercise, not to carry it to the extent of causing weariness, but should, as far as possible, make their exercise passive by riding until their natural feeling of strength and vigour is well restored. They should, as far as possible, occupy rooms that are well ventilated, dry, and cleanly; and their diet should be plain, nutritious, and readily digestible. They should endeavour to avoid all sudden exposures to cold and damp air, and still more to confinement in close, ill-ventilated, and over-heated rooms either day or night.

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A judicious observance of these rules, during the early part of the convalescence from diphtheria, would prevent a large proportion of the cases of paralysis that might otherwise occur. The same rules apply to the management of cases after paralysis has become manifest, only that the attempts at exercise should be more restricted, and the patient kept a large part of the time at rest.

Second, the views I have presented concerning the nature of the paralytic affection, suggests the use of such therapeutic agents as are capable of promoting the processes of assimilation and nutrition, and of increasing the susceptibility of the nervous and muscular structures. Among the agents best calculated to promote the former are good air, easily digestible food, hypophosphites, mineral acids, and bitter tonics. For increasing the latter we have no more efficient agents than some of the preparations of iron, strychnia, electricity, etc. When your attention was first directed to the patient before you, two weeks since, I directed him the following prescriptions:—

℞. Strychniæ sulph.	0.066 grm.
Acid. nit.	4.000 grms.
Aqua	128.000 "

Mix.

Take five grammes (one teaspoonful) before each meal-time in a tablespoonful of sweetened water.

℞. Ext. malt	128 grms.
Comp. syrup hypophosphites	64 "

Mix.

Take eight grammes (one dessertspoonful) after each meal-time.

He was supplied with good bread, milk, tenderly-cooked meat and vegetables, as much, at the regular meal-times, as his appetite required. I prohibited the use of wine, beer, and all alcoholic remedies, because in even small quantities the alcohol lessens the oxygenation and decarbonization of the blood; impairs the susceptibility of both nervous and muscular structures; and favours fatty degeneration in the metamorphic changes constantly taking place in the tissues, all of which are decidedly contraindicated by the nature of the disease we had to treat. Two days later there was added to his treatment gentle electro-magnetic currents for a few minutes every second day. He has steadily pursued the treatment thus directed until the present time, without any material change. And now, as he gets up readily from his chair, and walks steadily across the room without help, you see that he has recovered a very good use of his limbs, and is much improved in all respects. I shall now let him restrict the use of the strychnia and nitric acid to one dose every morning, but continue the ext. malt and hypophosphites as before; and if he is reasonably judicious in regard to his attempts to exercise, and cautious about undue exposures to sudden atmospheric changes, in two weeks more he will have so fully recovered that he will need no further use of medicines. In treating other cases of this form of disease, I have in most instances given the strychnia in combination with the citrate of iron, instead of with the nitric acid. But, gentlemen, if you apprehend clearly the objects to be accomplished in the treatment of any given case, you will generally find little difficulty in selecting proper remedies for their accomplishment.

HOSPITAL NOTES AND GLEANINGS.

Notes of two Cases of Abscess bursting into the Lung.

CASE 1. *Dysentery; Hepatic Abscess perforating the Diaphragm; Recovery.*—J. W. Seaman, aged 38, was admitted into the Northern Hospital under the care of Dr. CATON on July 18, 1877. Patient is pale and emaciated. He has suffered from dysentery for some weeks, and now passes eight or ten loose slimy stools per day. He has much tenemus. Liver dulness considerably increased upwards; tenderness on pressure, and some degree of pain referred to the liver; pain increased if he lies on the right side. He has no cough or dyspnœa. Throughout his illness he has been free from chest symptoms. Temperature 98.4°. Milk diet was ordered, a mixture of ipecacuanha, bismuth and morphia, and morphia suppositories.

July 21. Pain in region of liver is

worse. To-day a severe and sudden attack of dyspnœa came on, with much coughing, and patient expectorated about four ounces of pus, after which the breathing became easier. Coarse râles heard in the right lung; no friction. Pulse now and during the following six days varied from 100 to 110; temperature from 98.4° to 101.6°. No material change was made in the treatment. A firm broad flannel bandage was applied round the lower part of the thorax. The patient was told to lie as still as possible in bed, and to avoid violent coughing as far as he could, in order to diminish the risk of breaking down the adhesions believed to have formed between the liver, diaphragm, and lung.

During the week succeeding July 26 his condition gradually improved.

28*th.* Liver dulness has diminished. There is now but little pain unless he attempts to turn on the right side. A small amount of pus still expectorated. Temperature, morning 99°, evening 101.6°; pulse 107. Complains of weakness.

30*th.* A cutting pain complained of below the angle of the right scapula. Friction heard at the right base. Mustard poultices applied. Temperature 99°.

31*st.* Friction louder. Temperature 99.4°. Cough ceasing.

August 2. Friction becoming indistinct. Pain only felt on coughing or taking a deep breath.

3*d.* Friction almost inaudible. Still some degree of dysenteric diarrhœa, but in every other respect patient is improving rapidly.

14*th.* Powder of ipecacuanha gr. x, and opium gr. j, given twice daily. The diarrhœa now subsided, and the patient was allowed to get up. His diet was increased; he gained flesh and strength rapidly, and he was discharged cured on September 6.

CASE 2. *Axillary Abscess perforating the Thoracic Wall; Recovery.*—Annie L., aged eight, was admitted into the Liverpool Children's Infirmary, suffering from severe cough.

Previous History.—A fortnight before the patient's admission a painful swelling appeared in the left axilla, and subsequently increased to the size of a small orange. It was believed to be an abscess, and poultices were applied, but it showed no disposition to point outwardly. The child at this time was in good general health, had no sign of chest disease, and was perfectly free from cough. About three days prior to admission she began to complain of pain in the left side of the chest when taking a long breath, and a slight cough appeared. Next day a sudden attack of dyspnœa occurred, followed by severe coughing; a quantity of yellow frothy fluid was expectorated.

On admission, I found a soft fluctuating tumour about the size of a small orange in the left axilla. The swelling could be seen and felt to contract coincidently with forcible inspiration, and to expand with forcible expiration; and when the child coughed, a strong impulse was transmitted to the hand. When the stethoscope was applied to the tumour, a bubbling, gurgling sound of extraordinary loudness was heard coinciding with the respiratory movements. The left lung, especially at its upper part, was full of coarse râles. No friction was discoverable. The child coughed occasionally, bringing up a frothy yellow fluid, which the microscope showed to be pus. Her strength and appetite continued good, and she had no fever. The diagnosis seemed clear: an axillary abscess had pointed towards the pleura; inflammation, adhesion, and perforation of the two pleuræ followed, and the pus had found its way into the lungs. The treatment adopted was very simple. Danger of two kinds threatened—the adhesions might yield, and allow air and pus to enter the pleural cavity; also, the violent rush of air into the sac of the abscess during coughing was likely to produce general emphysema. It was evident that the sac must be emptied, and its communication with the air-passage closed as soon as possible. Placing the hand over the abscess, I slowly and gradually pressed out all the air and pus it contained into the lung, causing in the process violent coughing and some embarrassment of respiration. Probably two or three teaspoonfuls of pus were expectorated at the time. A firm and suitably shaped pad was then placed over the abscess so as to keep its wall in apposition, and this was carefully secured in its place by a bandage. Rest, a simple milk diet, and a gentle expectorant were ordered. Two days later, on removing the pad, only a small amount of air entered the sac during coughing, and but slight bubbling could be heard. The expectoration had diminished. Four days later no evidence of a cavity could be found on removing the pad, and the râles had almost disappeared from the lung; no friction was heard at any time. In a few days the child was perfectly well.

Remarks.—Cases of hepatic abscess discharging by way of the air-passages are by no means rare. During the last twenty-five years a considerable number have been recorded in the journals. Next to a direct outlet through the abdominal walls this appears to be the safest direction the escaping pus can take; still, it is attended by great risk: the adhesions frequently give away, and the contents of the abscess are poured into the pleural or peritoneal cavity. I have recently had a case in which an abscess, situated in the posterior part of the liver, pointed towards the diaphragm; adhesions were found, and the matter had burrowed through the diaphragm so far as to set up adhesive inflammation between the two layers of the pleura, when, unhappily, the lymph gluing together the liver and diaphragm gave way, and a quart of pus was poured into the peritoneal cavity, causing speedy death. The risk may perhaps be somewhat diminished by making the patient wear a firm broad binder round the waist, and by enjoining the most absolute rest. If the abscess can be diagnosed sufficiently early, there can be no doubt that its contents should be removed by aspiration. The second case narrated is one of great rarity. I have been unable to find a parallel to it in the journals.—*Med. Times and Gaz.*, Oct. 5, 1878.

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Cystic Adenoma of Breast treated successfully by Incision and Antiseptic Dressing.—Mary P., aged forty-one, single, a seamstress, was admitted to Mr. WEST's ward in the Queen's Hospital, Birmingham, on July 1st, 1878. No history of tumour in the family. She has had no illness or injury to the breast, and is in good health. About three months ago she perceived a swelling in her left breast, which she thought subsided after a time, and then reappeared, and continued to grow until it became as large as an orange. No redness, pain, or œdema, and the skin freely movable over the tumour; no retraction of nipple; axillary glands normal. There being a distinct, though deep, sense of fluctuation in the tumour, Mr. West introduced a grooved needle, when an ounce of thin serous-looking fluid escaped, which, on examination, was found to contain blood, fat, albumen, cholesterin, and some large irregular-shaped cells having the appearance of ground glass. The same evening the breast became painful. The pulse was 120, and the temperature rose to 101°. On the following day the breast was very painful, indurated, and swollen, and had a reddish-blush over it; sense of fluctuation very evident. Temperature 100°; pulse 108.

Three days after the first puncture, the redness, swelling, and pain having increased, two free incisions were made in the summit and base of the tumour respectively, under the antiseptic spray; six or seven ounces of pus were evacuated, the cavity well washed out with carbolized water, and a drainage tube introduced from one opening to the other. The breast was dressed antiseptically for a week after the operation; discharge was copious, but sweet; and no constitutional disturbance of any kind ensued. After the first week the openings were injected with solution of sulphate of copper (five grammes to the ounce), and the antiseptic dressing only applied every other day. At the end of a fortnight the swelling had completely gone down, discharge had ceased, and there was scarcely a trace of induration about the breast. She was discharged from the hospital cured on July 22d, the breast being strapped in the ordinary manner so as to keep up steady and equable pressure on it for some weeks.

Remarks.—This case serves to illustrate the good effects of free incision in cystic adenoma of the breast, and also the freedom from danger with which such operations can be undertaken when Lister's method is employed. No constitutional excitement of any kind followed the free opening of the cyst in this case when the carbolic spray was used and the breast dressed antiseptically, while simple puncture with a grooved needle made without those precautions was followed by violent inflammation of the cyst, so that the serous contents in three days became converted into pus, and great febrile disturbance was set up, as shown by the pulse rising to 120, and the temperature to 101°. The use of sulphate of copper injections to set up adhesive inflammation in the interior of the cyst, so as to agglutinate its walls, was attended by no constitutional excitement, as, at the same time, the antiseptic dressing was employed.—*Lancet*, Sept. 21, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Investigating the Yellow Fever Epidemic.—Acting upon the advice of members of the American Public Health Association, Dr. J. M. Woodworth, Surgeon-General of the Marine-Hospital Service, has organized a commission to gather and record all important facts relating to the commencement and spread of the present epidemic of yellow fever, with the view of establishing truths upon which the theory and practice of prevention of future epidemics may rest.

The gentlemen composing the commission—Prof. Bemiss, of New Orleans, Dr. Cochran, of Mobile, and Prof. Howard, of Baltimore—have already commenced their work in New Orleans, and will visit the principal places in which the yellow fever has prevailed. Col. Hardee has been added to the commission as sanitary engineer. The cordial co-operation of all who have facts to communicate bearing upon the subject under investigation, is earnestly solicited for the commission by Surgeon-General Woodworth. A preliminary report of the facts, gathered up to the 19th day of November next, will be presented to the American Public Health Association, which will convene on that day in the city of Richmond, to discuss the report, and to advise the best course to be pursued in concluding the labours of the commission. It is not intended to terminate the investigation on the 19th of November, but it is desirable that those interested in public hygiene, in all parts of our country, should meet in council prior to the assembling of Congress, as it is generally believed that legislative action will be promptly taken in reference to preventing future epidemics. The agitation of the public mind upon this important subject is proper and commendable, but herein lies the peril of hasty or not fully matured legislation, and it is hoped that by the action proposed, Congress may have the benefit of the representative men of sanitary science.

Treatment of Yellow Fever.—Dr. S. M. Bemiss, of New Orleans, thus describes (*Louisville Med. News*, Oct. 12, 1878) his mode of treatment of yellow fever. He says there is no known treatment, either antidotal or eliminative, which cures. If it is allowable to say that any disease has a "tendency to recover," the remark is certainly applicable to yellow fever. The very moment the paroxysm ends, attempts at convalescence are set up even in the worst cases, while in the mildest, convalescence dates from the time the fever ends. It is therefore true that while a certain proportion of cases are no more possible of cure than it is possible to arrest the march of a tornado, the *great majority* will recover if the surrounding conditions and the management are at all favourable to recovery.

I begin treatment with a cathartic—calomel, if the tongue is much furred, or, if an irritable stomach renders its selection necessary, castor oil, if only the removal of feces is desired. The salines are too irregular in their action. As the attacks of yellow fever are often very sudden, they sometimes catch a patient with a full stomach. An emetic under these circumstances is a smaller evil than to begin treatment with a burdened digestive system. A warm foot-bath given under the bed-clothes is very important as an early step in treatment. This seldom fails to induce very abundant diaphoresis, which should be promoted by adapting the covering to circumstances of temperature, of atmosphere, or the patient's condition as to surface. I do not for a moment doubt the ordinary hypothesis that sweating removes yellow-fever poison, but it does not follow that sweating alone is a cure; on the contrary, too much urging of the sweat-glands is often fatal, either by exhausting the patient or by disturbing the balance of functional integrity; in other words, damaging some other function, more particularly that of the kidneys. After catharsis I generally give by enema, in one or two ounces of flaxseed emulsion, fifteen to twenty grains quinia in solution. If much pain be present, ten drops of Battey's solution are added. After this no more medication except for symptoms.

The patient must be kept *absolutely* recumbent, not even permitted to raise his head from the pillow; cold drinks (lemonade, Apollinaris, Seltzer, Bethesda, or plain ice-water) in quantities not over one or two tablespoonfuls every half hour to an hour. No food should be given till late in third day, unless the patient is a child, previously an invalid, or unless a weakened and hurried pulse admonishes us that the fast cannot be longer endured. The first food should be of a liquid character; thin chicken water, barley water, iced milk diluted with a little lime-water, beef-tea, etc. Should the patient desire stimulants, they may be given in form most acceptable to him, whether fever be present or not. The effervescing drinks are generally preferred, either champagne, brewer's beer, or the porters. When fever returns after the paroxysm is over, it should be met by cold or tepid sponging of the surface. For this purpose water dashed with whiskey, vinegar, bay rum, cologne, or Raspail's sedative may be used. Never try to break the second or third paroxysms of fever by foot-baths or attempts at sweating. Cold sponging is beneficial for these returns of fever, but cold douching, or Kibbe's method, is apt to kill the patient by perturbing him to too great a degree. If necessary to free the bowels during the calm stage, it is better to do so by rectal injection. No visiting, or even unnecessary talking or noise, should be permitted in the patient's room. Vomiting should be met with epispastics, blisters, ice, and very *small* doses of opium in combination with cherry-laurel water and bicarbonate of soda; hemorrhages with ergot.

Trained nurses are very necessary to success.

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Abstract of Sanitary Reports received up to Oct. 26th, 1878, *under the National Quarantine Act.*

New Orleans.—During the week ending October 25th, there were 699 cases of yellow fever and 229 deaths. Total cases 12,881, deaths 3864.

Plaquemine, La.—Total cases of yellow fever to Oct. 20th, 1159. Total deaths 125.

Baton Rouge, La.—For the past week there were 170 cases of yellow fever and 15 deaths. Total cases 2340, deaths 144.

Morgan City, La.—There were 7 deaths from yellow fever during the past week. Total cases to date 510, deaths 94.

Port Hudson, La.—Report to Oct. 20th gives total cases of yellow fever 75, total deaths 10, including four resident physicians. The first case of the fever occurred Sept. 9th, first death Sept. 13th.

Mobile, Ala.—There were 71 new cases of yellow fever and 17 deaths during the week ending October 25th. Total cases 164, deaths 49.

Ocean Springs, Miss.—No deaths from yellow fever during the week ended at noon, October 25th. There were 8 new cases in Ocean Springs, and 9 cases in the country not previously reported. Total cases 145, deaths 29.

Pass Christian, Miss.—For the past week there were 44 cases of yellow fever and 5 deaths. Total cases 170, deaths 18.

Water Valley, Miss.—Total cases of yellow fever to yesterday evening 146, total deaths 60. Six new cases Oct. 25th.

Port Gibson, Miss.—The yellow fever has spread into the country. As near as could be ascertained about 30 deaths occurred in the past week.

Hudson, La.—To Oct. 13th there had been 75 cases of yellow fever and 18 deaths.

Germantown, Tenn.—The first case of yellow fever occurred August 20th. First case among inhabitants August 25th. Total cases to noon October 15th 65, deaths 36.

Memphis, Tenn.—For the week ended the evening of the 24th inst. there were 50 deaths from yellow fever. Total deaths 2942.

Brownsville, Tenn.—During the week ended yesterday evening there were 16 deaths. Total cases 560, deaths 152.

Chattanooga, Tenn.—For the past week there were 80 cases of yellow fever and 23 deaths. Of these 51 cases and 9 deaths were among coloured people.

St. Louis, Mo.—At quarantine during the past week 3 residents were admitted and died of yellow fever. One patient previously reported also died of yellow fever

Cairo, Ill.—For the two weeks ending October 25th, there were 44 cases of yellow fever, and 6 doubtful cases. Deaths for the same period 16. Total cases 75, deaths 41.

Louisville, Ky.—There were 4 new cases of yellow fever for the week ending October 25th, and 7 deaths. Total cases 131, deaths 61, including refugees.

Decatur, Ala.—During the week ending October 25th there were 23 new cases of yellow fever and 13 deaths. Total cases 178, deaths 40.

Biloxi, Miss.—Up to Oct. 17th there were 295 cases of yellow fever and 40 deaths.

Greenville, Miss.—To noon of Oct 11th there were 301 deaths from yellow fever, 21 of which were in the country outside of Greenville.

No cases of yellow fever or deaths during the past week at *Port Eads, La.*, *South West Pass, La.*, and *Key West, Fla.*

Havana, Cuba.—23 deaths from yellow fever and one from smallpox for the week ending Oct. 19th.

Hernando, Miss. — During the week ending October 25th there were 32 cases of yellow fever and 7 deaths. Total cases 165, deaths 63.

No reports received from the following places where yellow fever exists: Vicksburg, Miss., Holly Springs, Miss., Canton, Miss., Grenada, Miss., Bay St. Louis, Miss., Friar's Point, Miss., Mississippi City, Miss., Spring Hill, Miss., Crystal Springs, Miss., Hickman, Ky., Grand Junction, Tenn., Paris, Tenn.

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Typhoid Fever conveyed by Milk.—Epidemics of typhoid fever generated by milk contaminated, through the water supply, by the excreta of typhoid fever cases being placed into such proximity as to drain into the latter, are unfortunately of such frequent occurrence that the Parliament of Great Britain has, in the Contagious Diseases (Animals) Act, given authority to the Privy Council to make such rules and orders as may be deemed proper for the registration and inspection of dairies and all that pertains to them, and to prescribe the necessary precautions to be taken for protecting milk against infection or contamination, and to authorize the carrying out of the same by the local authorities.

The importance of this matter in the interests of Preventive Medicine cannot be overestimated, and we are gratified to learn that at least one institution in this country in which a large number of children are collected, and consequently in which a large quantity of milk is consumed (The Pennsylvania Institution for the Deaf and Dumb), has had made a sanitary inspection of the dairy from which its milk supply is received, so as to guard its inmates against this possible and preventible source of epidemic disease. We cite this example because we think it should be followed by all kindred institutions. At this very moment there exists an epidemic of typhoid, from contamination of the milk supply, at Bristol, England. In the early part of the year there existed others at Manchester, Ascot, and at Glasgow. The history of the latter has been written and we learn that 163 cases were traced to infection from this source. Within the last few years there have been a number of similar epidemics in Great Britain. Yet, all these cases of sickness and death, and the long list of woes therein entailed, were preventible by timely sanitary inspection of the dairy farms from which the milk supplies were received. This the British Government now looks forward to having systematically done.

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American Public Health Association.—The sixth annual meeting of this association will be held in the city of Richmond, Va., from the 19th to the 22d of November to consider the reports and propositions offered by its members and others relating to the epidemic and the sanitary measures for preventing the recurrence of such calamities. The first days of the sessions will be devoted to the report and evidence submitted by the yellow fever commission under the Surgeon General of the U. S. Marine Hospital Service, as that important work has been undertaken with the advice and co-operation of members of this association.

The results of the labours of that commission and of the deliberations of this meeting will, it is believed, be of very great importance to the nation, while they will promote needed legislation and determine most essential reforms in public health government. Contributions of information and study relating to yellow fever and the epidemics of the present year are solicited from all quarters; a general invitation is extended to all interested in sanitary science to attend the meeting and participate in its work.

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Personal.—The *Lancet* (Oct. 5) announces that Mr. Callender of St. Bartholomew's Hospital will visit this country early in December with the intention of seeing the practice and teaching arrangements of the prominent surgeons of the United States.

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OBITUARY RECORD.—Died, at Philadelphia, on the 7th of September, of cancer of the kidney, WASHINGTON LIGHT ATLEE, M.D., aged seventy years. Dr. Atlee was widely known as a successful ovariotomist, and author of a work on Ovarian Tumours.

FOREIGN INTELLIGENCE.

Spontaneous Fracture of both Thighs.—Dr. NEDOPIL, clinical assistant of Prof. Billroth, relates (*Wien. Med. Woch.*, July 30) the following very remarkable case. A Privat-beamte, aged thirty-two, a strong and healthy-looking man, was admitted to the clinic. With the exception of a hard syphilitic ulcer, which showed itself in 1868, and an exanthem which followed it about two years afterwards, he has always remained in good health. He was not subjected to any complete anti-syphilitic treatment. Some years ago he married, and has two healthy children. On July 6, 1876, while walking on even ground, he fell down; and, on being raised, the left femur was found to be broken just below its middle. For six or eight weeks prior to the accident he had complained, after much walking or standing, of dull pains in the bones, especially during the evening, which, however, did not prevent his sleep. The patient felt sure that the limb was already broken when he fell. He was treated at his own house, the cure being completed in about ten weeks, with about three centimetres shortening of the limb. On May 6, 1877, he came to the clinic, having since March been tormented with the same kind of pains, only much more intense, in the right limb as those which had preceded the fracture of the left. Iodide of potassium and baths were prescribed. On July 6 (exactly one year after his former accident), having tripped on getting out of the bath, a fracture occurred at just above the middle of the right femur. He recovered in about the same time, and, when seen in September, there was scarcely one centimetre difference between the limbs, and he was able to walk perfectly when the pains had left him. In February, 1878, however, these returned severely in the limb last broken. Baths and the Haller iodine water were prescribed, and last June he was much better, of very healthy appearance, and able to walk well by aid of a stick. Dr. Nedopil is of opinion that the accidents have arisen from a diseased state of the bone, due to the syphilis which he contracted about nine years ago.—*Med. Times and Gaz.*, Oct. 5, 1878.

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Sweating in Phthisis.—Dr. Cérenville, Senior Physician of the Lausanne Hospital, states (*Union Méd.*, Sep. 24) that from frequent use of the sulphate of atropia (one milligramme as a dose given in the evening) in the sweating of phthisis, he can corroborate the good opinions of its efficacy published by Drs. Fraentzel and Williamson. He generally finds that the first dose diminishes the sweating, while after the second or third dose it becomes arrested.—*Révue Médicale*, September 23.

Professor Germain Sée prescribes five grammes of tannic acid and one gramme of alcoholic extract to be made into forty pills, of which eight are to be taken daily. Prof. Potain prescribes from six to eight grammes of the phosphate of lime daily. —*Med. Times and Gaz.*, Oct. 5, 1878.

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Treatment of Wounds by Salt.—M. Houze, in a paper (*Rév. Scientifique*, Aug. 31), read at the French Association, stated that he had met with great success in treating wounds with abundant purulent discharge and purulent collections by means of a saturated solution of salt. He attributes its beneficial effects to its antiseptic action and to the density of the solution. If we place some pus and a solution of chloride of sodium in a test-glass, the pus soon appears at the surface of the mixture. M. Cabello, of Madrid, stated that he had employed sea-water in the treatment of atonic ulcers with good effect. M. Rochard, on the other hand, stated that he had found that the little ulcers sometimes forming on the feet of sailors become transformed into chronic sores when the feet are exposed to the action of sea-water, so that men having such ulcers are obliged to be exempted from service. M. Lecadre has often seen sea-water employed with benefit in the treatment of wounds.—*Med. Times and Gaz.*, Oct. 5, 1878.

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The Therapeutical Action of Digitalis.—Prof. Teissier of Lyons, in a communication to the French Association (*Rév. Scientifique*), observed that notwithstanding that so much has been written on the subject, great uncertainty exists as to the employment of this remedy in heart disease. While some reserve its use for mitral lesions, others make it out to be the remedy *par excellence* in affections of the aorta. Under the influence of M. Bouillaud, it used to be regarded as exclusively sedative, while more recently it is said by stimulating the nerves of the heart to increase arterial tension—Prof. Gubler declaring that it is not the "opium," but the "cinchona" of the heart. After a clinical experience of thirty-five years, Prof. Teissier has come to the conclusion that there are few affections of the heart in which it is not a suitable medicine, and that it becomes in turn sedative or stimulant, according to the condition of the heart. He does not regard either hypertrophy or aortic affections as contraindicating its employment; and as to the diseases of the right side of the heart, they can but benefit by a remedy which both increases the *vis a tergo* and increases the circulation. Prof. Gubler observed that digitalis is truly a tonic of the heart, although its tonic action may be only indirect. The cases in which it succeeds best are those where the cardiac disorders are most considerable, the increased energy being accompanied by debility of the organ. Every one is aware that, as regards force, there is a great difference between the impulse of the heart and the arterial pulse, all having seen cases wherein, while the heart beats violently, the pulse remains small and feeble. It is in such cases that tonic action is advantageous, digitalis proving useful when the cardiac action is the dominant feature. The true contraindications are found in the fundamental feebleness of the heart and irregularities of rhythm—what may be termed cardioplegia. Prof. Gubler considers that sphygmographic tracings are highly deceptive, the positions of the instrument with relation to the artery entirely changing their character.—*Med. Times and Gaz.*, Oct. 5, 1878.

Treatment of Whooping-Cough by Tincture of Drosera.—A paper which appeared on June 25th, 1878, in the *Journal de Thérapeutique*, by Dr. Lamare, on the Treatment of Whooping-Cough by the Tincture of Drosera, has excited considerable attention, and the effects obtained by various observers have been different. M. Créquy, in a child of three months, rapidly effected a reduction in the number and violence of the fits of coughing, so that from the end of the fifth day they almost completely disappeared. The same result occurred in another child of three years, recovery being almost complete in about fifteen days. Mr. C. Paul, however, was less fortunate, the remedy appearing to be without action. The plant used is the Drosera rotundifolia. Its digestive properties are well known since Mr. Darwin's observations upon it, and further investigation would be serviceable.—*Lancet*, Aug. 3, 1878.

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Anorexia.—Dr. FONSSAGRIVES recommends (*Union Méd.*, July 9) the following formula:—Bruised Chinese rhubarb, bruised peel of bitter orange, of each four parts, and water 250 parts. This is to be infused cold during three days. Two or three tablespoonfuls are to be taken daily an hour before dinner. If this does not succeed, he prescribes one or two pills an hour before dinner, each containing one centigramme of alcoholic extract of nux vomica, and twenty centigrammes of extract of gentian, continuing them until the appetite is suitably restored.—*Med. Times and Gaz.*, July 20, 1878.

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Cerebral Localization.—M. GOUGENHEIM adds, in an observation recently communicated to the Société Médical des Hôpitaux de Paris, a new observation of cerebral localization; a case of monoplegia of the left leg, following a fall upon the head; there was no loss of sensation. The diagnosis was cortical lesion, localized in the upper extremity of the ascending frontal convolution. The *post-mortem* examination showed a lesion of the ascending frontal convolution, limited to the external surface of paracentral lobe. This corresponds to Ferrier's determination of the psycho-motor centre of the muscles of the lower extremity.—*Brit. Med. Journ.*, May 25, 1878.

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British Medical Association.—The forty-sixth annual meeting of this Association was held at Bath, August 6th, 7th, 8th, and 9th, under the presidency of Dr. R. W. Falconer, of Bath. Drs. L. A. Sayre, of New York; Billroth, of Vienna; Charcot, of Paris; Esmarch, of Nice; Liebreich, of Berlin; Ludwig, of Leipsic; and Pasteur, of Paris; were elected honorary members. At this meeting final action was taken on the addition to the Articles of Association which was proposed last year, viz., "That no female be eligible as a member of the Association." After full discussion the following amendment was passed by a large majority, "That no female shall be eligible for election as a member of the Association."

At the Public Dinner of the Association Dr. Marion Sims, as a delegate from the American Medical Association, responded to the toast of "The Guests."

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Quinoidine as a Febrifuge.—At a late meeting of the Académie de Médecine de Paris, M. BURDEL, of Vierzon, read a paper on the Febrifuge Action of Quinoidine in the treatment of Telluric Fevers. M. Burdel remarked that this resin-alkaloid possessed distinct febrifugal properties, and that it is closely analogous in its action to quinine. He finds that, like quinine, it may be freely administered, and with good results, in telluric and benignant intermittent fevers. But it is in quartan fevers and in telluric cachexia that it exerts a specially well-marked action; in these it is even superior to quinine. Like all analogous febrifuge remedies, quinoidine should be given for four or five weeks consecutively, in successive but properly timed doses. Its relatively low price is a great point in its favour. It cannot, M. Burdel thinks, supplant quinine in the treatment of intermittent fevers of an acute type, but it may even in these be a useful auxiliary; whilst in chronic cases he believes that it is actually superior to quinine.—*Lancet*, Aug. 21, 1878.

Colour-Blindness.—By a recent order of the managing directors of the German railways, their officials have been subjected to trying tests, with the view of ascertaining their ability to distinguish clearly between red and green lights; and the result has been that a very considerable number of men have had to be removed from their posts, and provided with other employment, in consequence of colour-blindness.—*Med. Times and Gaz.*, October 12, 1878.

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Venesection as an Anti-Hemorrhagic.—Professor Chauffard is of opinion (*Abeille Médicale*) that at the present time venesection is too much neglected, and especially in cases where it is desirable to open up another channel for blood which tends to become effused at the surface of an organ. He pointed out a case of hæmoptysis at the Necker, occurring in a robust young man who was almost plethoric, a stone-cutter by trade, and therefore of an occupation dangerous to the pulmonary organs. A very abundant hæmoptysis had appeared suddenly three days before his admission, and still continued. Prof. Chauffard having ascertained that no serious lesion existed, ordered venesection to the extent of 500 grammes, and the cure was immediate and complete. This is the reverse of what is met with when a normal hemorrhage which is suppressed gives rise to another in its place. It is not only an accidental hemorrhage which may be thus arrested, but also the hemorrhagic molimen when it becomes dangerous. Thus one of the most important applications of venesection in practice is for the prevention of catamenial congestions persisting after impregnation, and leading to the detachment of the germ—a cause of sterility which is frequently misunderstood. A case in point is that of a lady who, during a period of ten years, repaired to every resort reputed as useful for the prevention of sterility. She was a stout and plethoric person, with very abundant menstruation, which appeared at regular periods. In neither her nor in her husband was there any cause preventive of impregnation. This had probably taken place, but had been rendered invalid by reason of the abundant periodical discharge which had continued. The day before the expected period a small quantity of blood was taken, and then again the next day; and at the end of nine months the lady had her first child, which was followed by others. This cause of sterility, especially in persons of generous blood, is by no means rare.—*Med. Times and Gazette*, October 12, 1878, from *Presse Belge*, Sept. 29.

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Tincture of Myrrh in Pertussis—Another remedy for whooping-cough, and, like all its predecessors, simple and efficacious, is brought forward by Dr. Campardon, who, on the strength of several cases treated with it, strongly recommends the tincture of myrrh in doses of from three to ten drops, given several times a day in vinum cinchonæ, although this is not an indispensable vehicle. It in nowise militates against the appropriate treatment of any inflammatory complication that may arise—*Med. Times and Gaz.*, Oct. 12, 1878, from *Bull. de Thérap.*, Sept. 15.

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Obituary Record.—Died on the 14th of September, in the seventy-fourth year of his age, John Hilton, Surgeon-extraordinary to H. M. the Queen, President of the Royal College of Surgeons, and Consulting Surgeon to Guy's Hospital.

—— At Barnes, Surrey, on the 21st of September, Robert Willis, M.D., Ed., at the age of eighty years.

Dr. Willis was for many years librarian of the Royal College of Surgeons, and was the editor of the Sydenham Society's edition of the works of Harvey and the author of the life of Harvey appended thereto.

—— At Bex, Switzerland, on August 1st, aged 65, Hermann Lebert, formerly Professor of Clinical Medicine at Zurich. Prof. Lebert is best known in this country by his great work on Pathological Anatomy, the first part of which was published in 1854, and was not completed until 1862.

—— At Toulouse, aged 79, Achille Foville, the distinguished French Chemist and author of the *Traité de l'Anatomie de Système Nerveux Cérébro-spinal.*

4

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ON NERVOUS SYPHILIS.

A Clinical Lecture delivered at the Charity Hospital, New York.

By W. H. VAN BUREN, A.M., M.D.,
Professor of Principles and Practice of Surgery in Bellevue Hospital Medical College.

I PROPOSE to close our clinical demonstrations of the venereal diseases by the study of some cases, which have been selected from the wards, of *Nervous Syphilis*. This term is employed to designate the effects of the syphilitic poison upon the nervous centres and the nerves. Our knowledge of these manifestations has grown up entirely within the past thirty years. Dr. Reade of Belfast, Ireland, in 1847, and Dr. Todd of London, two or three years later, first pointed out the true relation between these phenomena and their cause; and the study of the subject has since occupied some of the best minds in the profession. The result has been an increase in our power of relieving many hitherto obscure forms of nervous disease, which are thus brought within the influence of valid remedies.

The first case is a woman of 30, with a pallid aspect, as you observe, but well nourished, and bearing upon her face several solitary circular ulcers partially covered with crusts, and seated upon elevated livid bases. She has, also, old pigmented, circular, smooth cicatrices on the legs and thighs. Her history states that in a miscarriage, two months ago, in which a good deal of blood was lost, she became hemiplegic, and in this condition was brought to the Hospital. I am unable to learn from her whether or no she lost her consciousness at the time she became paralyzed, for, as you perceive, she is the subject of exaggerated emotional manifestations of distress, which are not hysterical, but due, rather, to a lack of

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

☞ *In no case is this periodical sent unless the subscription is paid in advance.*

cerebral power suggestive of idiocy. This mental condition, usually described as *hebetude*, is a not infrequent symptom of nervous syphilis. I once attended a young German merchant who sat most of the time with a vacant expression on his face, and the saliva drivelling from his half-open mouth. His nurse was obliged to give him all his food by the spoonful, and coax him to swallow each mouthful, carefully cleaning out his mouth afterwards to prevent fragments from getting into the larynx—an accident by which he was once nearly choked.

I cannot get any evidence from this woman as to whether she has suffered from headache, but you observe that, whilst the hemiplegia affects the left arm and leg, when I make firm pressure over the right parietal bone, in front, she flinches distinctly. This evidence, in addition to what has been already gathered, justifies the inference that her symptoms are to be explained by lesions of tertiary syphilis developed within the cranium, and on the right side, probably gummy deposit, causing pressure, possibly by syphilitic changes in the cerebral arteries causing obstruction and consequent cerebral anemia; and that, under the judicious use of mercury and iodine, she has a chance of recovery.

The next case is also a hemiplegic woman, of about 40, with partially contracted flexor muscles of the right upper and lower limbs, and paralysis, on the same side, of the face and tongue. Her intelligence has not been impaired. She acknowledges an eruptive disease, which got well under mercury three years ago, and shows at present, circular, smooth, white, depressed scars on her arms, each one of which is surrounded by a delicate zone of pigment. You hear her very interesting statement of her attack: Ten months ago, whilst sitting, reading, she noticed tingling and numbness in the right foot and leg, and in the tongue, and, shortly, lost the power of holding her book. There was no loss of consciousness accompanying the invasion of these symptoms, but they were preceded by headache. They had persisted, and the present condition of contraction gradually followed. The remains of the facial paralysis are still evident, on the same side as the paralysis of the limbs. She has undergone no active treatment. Probably, if she had, her recovery would have been more complete, without the contraction, for the antecedents and the mode of attack are characteristic of hemiplegia of syphilitic origin. Headache, worse towards night, and better in the morning, with tenderness on firm pressure at some fixed point, and this point, in hemiplegia, almost invariably seated over the front and side of the anterior cerebral lobe, where the motor tract is now proved to be located, is significant of cerebral syphilis; as a precursor of hemiplegic symptoms, it is very rarely absent. It is a symptom never to be neglected in a syphilitic subject.

I have also learned to regard the absence of loss of consciousness at the moment of attack, as characteristic of the syphilitic form of the disease. In hemiplegia from extravasation, loss of consciousness is almost always present for a longer or shorter time varying with the size of the clot. I was called many years ago to a gentleman who, in the effort to get out of bed in the morning, suddenly found himself prostrate in the farther corner of the room, where the discovery that one of his lower limbs was powerless —and the knowledge did not come to him until he had brought the weight of his body upon it—compelled him to call for assistance. I found the upper extremity also paralyzed, but not so completely as the lower. One of his pupils was larger than the other; he had been under treatment, but at irregular intervals, for syphilis. He had gone to bed the night before as well as usual, and was utterly unaware that anything was wrong with him when he first made the effort to spring out of bed. Although actively treated by mercury alone, the improvement in this case was not satisfactory.

The third case, gentlemen, is a young man of 30, a butcher, who, as I learn from the note of his case taken by the House-surgeon, had been "cured," six years ago, of a general eruption recognized as syphilitic, by mercury, which he took for three months; after this he had an interval of perfect health for four years, and then awoke one morning with *facial paralysis and deafness*, on the right side. According to his own statement, he was not treated for these symptoms, and they gradually disappeared in about six months. Two years afterwards he found one of his legs weak on rising one morning, but got down town, where at breakfast, he noticed that the arm of the same side, also, became so weak that he could not manage his spoon, and the tongue became thick, so that he could hardly speak. These symptoms also passed off shortly, and at the end of an hour he went up town on a street car. In getting off the car, however, he found that his leg had again given out, so that he fell in the street, and was carried into a shop, where he found himself unable to explain his condition, as the "thickness" in his tongue had returned, and he was supposed to be intoxicated. Notice, if you please, as he answers my questions, that his intelligence and memory are unimpaired. Here, again, his symptoms passed off in a little time, so that he was able to walk to the shop of a friend about a block distant. Within the hour, however, they all came back again a little more suddenly and severely, and he lay helpless on the floor until the next day, when not recovering in any degree he was taken to Bellevue Hospital. Here electricity was applied, without benefit, and subsequently, iodide of potassium was administered, but, apparently, not in "efficient" doses, for now, at the end of three months, you recognize partial right hemiplegia still present, with some flexor contraction, and a trembling, on attempting to use the crippled arm, which recalls *paralysis agitans*.

In this case there was no loss of consciousness; and, by the repeated disappearance and return of the paroxysms within short intervals, it would seem that the cerebral substance had at least twice accommodated itself to the pressure of (probably) an intra-cranial gummy tumour before finally yielding to its persistent increase of size. This is the most obvious mode of explaining these successive waves of approaching paralysis, but I must tell you that the pathological anatomy of this form of disease is still uncertain, for Huebner has shown that most of the symptoms peculiar to cerebral and spinal syphilis may be caused by defective blood-supply as a result of gummatous thickening, to the point of entire occlusion, of the walls of the smaller arteries. But this question is of less practical importance than that of treatment. Even after complete hemiplegia had declared itself in this case, a prompt exhibition of iodide, in steadily increasing doses up to the point of efficiency, ought to have removed the cause of the symptoms more rapidly than the patient's present condition would seem to indicate had been accomplished. If the doses were efficient, we must conclude that the brain substance was broken down by pressure, or that it had become anæmic to the point of atrophy; but most likely the doses were not large enough.

I will remark that, where symptoms like those of this patient are preceded by localized headache, and tenderness on pressure, I should conclude that the gummatous exudation had taken the form of a tumour, rather than of arterial thickening and obstruction.

I bring before you, next, an anæmic looking man of 45, with *loss of muscular power of the right lower limb.* He has been under treatment in this Hospital within a few years for constitutional syphilis, and is now getting better under the use of the iodide. Sensation in the weak limb is, apparently, not much impaired, and as you see, although his gait is suggestive of locomotor ataxy, he walks fairly with his eyes closed. The case is one of muscular *paresis*, of a single limb, a condition which is not rare, and is exceedingly characteristic of nervous syphilis. A man may awake in the morning with the sensation of "pins and needles" in his arm, and before midday the upper extremity will be entirely powerless. When not the direct result of pressure on the nerves, or of other obvious injury, a case of paralysis of a single limb is almost certainly of syphilitic origin. I have seen a lower extremity of one side and an upper extremity of the other side of the body simultaneously affected. Not unfrequently both lower limbs are paralyzed, not necessarily completely, although this sometimes happens, but in most cases partially, so that the condition is one of *paresis*, usually, rather than *paralysis;* and there is often a sensation as though a cord were tied around the waist, and the bladder is slow in getting rid of its contents, and the rectum also. These symptoms are caused by gummatous thickening of the theca vertebralis, or by deposit of the same material in the substance of the cord. Partial obliteration of the arteries supplying the cord has also been found, and in some cases serous effusion causing symmetrical pressure by gravitation. Many of the not infrequent cases of partial and irregular paraplegia occurring early in life are due to this variety of *tabes dorsalis*, and I have relieved several cases which had been mistaken for locomotor ataxia.

The fifth case is a man of 45, who entered the hospital for a *defect of vision* which had been increasing gradually for several weeks. He was presented at our last clinic, when we recognized mydriasis and strabismus, also that the trouble in his sight was owing to the fact that he saw objects double. You remember that we made out no distinct history of syphilis, but found a large scar over the parietal bone which the patient explained as the result of a lump which came there without any local injury, and slowly softened, and ulcerated. The evidence was strong enough to justify the trial of antisyphilitic treatment. Now, at the end of a week, you have an opportunity of judging as to the effect of the remedy, and you see that it has aided very much in establishing the diagnosis, for the patient tells us that his sight has vastly improved since he began taking the medicine, and you observe that his squint has almost disappeared. With this, the diplopia has also gone, except when he looks in certain directions, proving that the defect in vision is due to the fact that the muscles of his right eyeball act imperfectly, and do not keep its axis always parallel to that of the left, in fact that there is paresis of the external rectus, the usual cause of internal strabismus. This weakness of a solitary muscle which has so seriously deranged the eyesight is due to disease of the nerve which supplies it, and this disease is proved, by the action of the remedy, to be syphilis. The nerves which supply the muscles of the eye are not unfrequently affected by syphilis. On more careful inquiry into the patient's history it has been ascertained that he was treated for the primary disease five years ago. The lump on the outside of his head was, therefore, pretty certainly a gummatous node; and the inference is fair as to the existence of a similar tendency to gummatous exudation within the cranium. I would advise, in such a case, that the iodide be continued in sufficient doses until the symptoms shall have entirely disappeared, and that the patient should be then subjected to the prolonged action of mercury in small doses, to diminish the liability to further outbreak.

The sixth case is a man of 31, with *facial paralysis* of some weeks' standing, which came on without any obvious cause. The patient, who is a printer, thinks that "the antimony in the type metal may have something to do with it," and "coming out of a hot room into the cold air." But he had a similar attack seven years ago, with no clearer cause, and before that he says he had "the venereal disease," and took mercury. He has also a depressed, white, circular scar, surrounded by a ring of brown pigment on the outside of his leg, and you see that when I make slight pressure upon the subcutaneous surface of the tibia, he flinches. The paralysis is evidently due to a syphilitic affection of the *portio dura.* The nerve lesion is incomplete or already getting better, for you see that with an effort he can nearly close the eyelids, and his tongue does not deviate. And yet his speech is quite indistinct; he hesitates, mistakes words, and his thoughts seem to come slowly and with effort. These signs indicate lesion of the brain, in addition to that of the cranial nerve; and such a coincidence, in nervous syphilis, often exists. In answer to my question, he says he has suffered much and long from headache for two years, and also from sleeplessness; and when I ask him if he finds that his memory fails him in his business, and if he is less clear-headed than formerly, he answers promptly, yes. A man's self-regard would lead him to hesitate before confessing that his mind is failing him, unless profoundly conscious of the fact; therefore I feel confidence in the truth of this evidence.

Here is a case of possible proliferation in the neuroglia of the cortical substance, interfering directly with the production of nerve force, by interrupting the function of the nerve-cells. The same lesion may exist in the neurilemma of the *portio dura;* or the periosteum lining the bony canal through which this nerve passes out of the cranium may be thickened in a similar way, and the nerve pressed upon. Or, again, the walls of the arteries at the base of the brain may be the seat of the same pathological change, by which their calibre is diminished and the blood-supply cut off, more or less from the parts of the brain to which they are distributed. I cannot certainly tell you which of these morbid changes is present in the case before you; possibly all of them. They all present a common feature, namely, a tendency to the production of a new material by cell development. This cell proliferation, which apparently does so much harm, is provoked, as far as we can judge, by the presence in the blood of the syphilitic poisonous element, which, in this stage of the disease, is liable to manifest itself by an injurious effect upon the tissues in certain localities, and often after long intervals of health. Why it acts just in this way, that is in certain localities, and at such long intervals, is, to use Mr. Hutchinson's expression, "one of the marvels of pathology." The brain furnishes several of these favourite localities, and when the defective blood has caused trouble here, in the form, probably of perverted nutrition, the first effect produced is an afflux of more blood to repair the damage, and this, constituting congestion, explains the headache. Congestion is followed by cell-proliferation, for the purpose of repair. Thus the pathological phenomena of cerebral syphilis in some degree lose their mystery, for they are identical with those which succeed injuries to the tissues from other causes, and come within the modern definition of inflammation. But the effort at repair is abortive, and takes the shape of gummy exudation. In the end, however, in most cases, reparation in some sort is accomplished by development of cicatricial connective tissue; for, after this phase of syphilitic disease shall have passed away, either spontaneously, as it sometimes does, or under the influence of treatment, in the localities where the microscope would have detected cell-proliferation, it now recognizes only the more bloodless tissue of cicatrix.

This man asks me anxiously, "Will I get well, sir?" My answer is, "My friend, I have great hope that you will." Now, let me ask you, gentlemen, would this prognosis be at all reasonable, or likely to be justified by the event, if the serious symptoms of brain trouble which this case presents arose from any other form of cerebral disease than this peculiar affection we are engaged in studying? If we had not indubitable evidence in favour of the diagnosis of "cerebral syphilis," the symptoms here present, involving disturbed intelligence and impaired utterance, would point to embolism, or some other serious lesion, and probable softening, with the worst possible prognosis. The prompt and generous exhibition of mercury by inunction, or vapour-bath, with the simultaneous use of iodine in efficient doses, has in my hands been frequently followed by immediate lightening up of these grave symptoms, and by apparently perfect restoration to health. This is a result which never follows treatment in true softening. The diagnosis of syphilis as a cause of nerve lesion carries hope with it, therefore, for the wonderful remedial virtues of mercury and iodine are at your command; and if the lesions are not so old that the stage of cicatrization and contraction has already been reached, these remedies seldom fail to show their power. The iodide should be given, as I advised when speaking of the treatment of rapid gummatous ulceration, in a steadily increasing dose, beginning with ten grains three times a day, and adding five grains a day to each dose, until the patient is taking a drachm and a half or even two drachms, unless marked amendment has occurred before this amount has been reached, or the stomach has given out. At the same time mercurial inunction, with the oleate, or the blue ointment, should be thoroughly carried out. I add the mercury because there are cases which will not yield to iodine alone; and where serious brain lesion is in question, it is safer to take every chance. And, let me tell you, there is a certain element of prompt audacity required to command success in these cases; a willingness founded on certainty of knowledge, to adopt heroic treatment, unhesitatingly, and without half-way measures, recognizing no other alternative in the way of treatment, by which a fatal issue, or what is even worse, a permanently damaged brain, can be prevented.

Our time has nearly expired, and I have yet other forms of nervous syphilis to speak of. For obvious reasons there has been no case of *epilepsy* or convulsive action brought before you, and to prevent an erroneous impression I hasten to tell you that epilepsy is one of the most common forms of nervous syphilis; indeed, when it makes its appearance after the period of adolescence, epilepsy is, as a rule, due to syphilis. There are certain peculiar features which stamp the disease when of syphilitic origin, such as antecedent headache, or an unexplained failure of the general health; the convulsive action is often partial in character, one limb may be attacked first; sometimes indeed, the fit is confined to an arm or a leg, or to one-half of the body, or there may be only a "half attack;" the loss of consciousness is slower in coming on, is less complete, and even sometimes entirely absent.

I told you once, that the skin symptoms of syphilis are characterized by irregularity; the same is true of its nervous manifestations. In some aspects they resemble hysteria; their very oddness and strangeness are not without a diagnostic value.

I will rapidly enumerate some of the more irregular nervous phenomena which I have satisfied myself are due to syphilis; sudden and transitory loss of speech, and at the same time, of power of writing: temporary suspension of mental power, with inability, at the moment, to command the ideas and the memory, as well as words, but without aphasia, what Mrs. E. B. Browning would call "vanishings"; sudden lapse of muscular power, perhaps in one limb only, causing the patient to trip or stumble, or to drop anything carried in the hand; tingling beginning at the tips of the fingers or toes, and passing away shortly; or persisting and ending, after a time, in motor paralysis or paresis, of a leg or an arm; tetanoid cramps of the spinal muscles, and more frequently nocturnal, as I have observed them, liable to be followed by temporary paralysis of the intercostal muscles with diaphragmatic breathing; impotence, in most cases temporary or relievable; mania, in one case with violent paroxysms ending fatally; and, finally, satyriasis, in one instance, of the most marked character, the patient having been regarded as the victim of profound and incurable cerebral disease by specialists in Europe. This patient afterwards married, and conducted an important business requiring considerable executive ability.

As to reading on this subject, English medical literature is not very full: Dr. Hughlings Jackson and Dr. Samuel Wilks are excellent authorities, and a small volume by Dr. Buzzard is sound, but puzzling from lack of lucid arrangement. There are several French monographs of great merit, by Lagneau, Zambaco, and Lanceraux. Prof. Keyes not long since collected from my records a number of cases, and, with his own additions, made a paper which I can recommend to you.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

American Public Health Association.—This Society convened at Richmond, Virginia, on the 19th ulto., and remained in session four days. The meeting was largely attended, and was presided over by Dr. Elisha Harris, of New York.

The following resolutions, submitted by the committee appointed to prepare propositions on yellow fever, were adopted.

"That the yellow fever of 1878 was a specific disease, not indigenous to or originating spontaneously in the United States, and its appearance in this country during this year was due to a specific cause." (This statement was adopted by a vote of 33 yeas to 11 nays.)

"That quarantine, established with such vigour and precision as to produce absolute non-intercourse, will prevent the importation of the specific cause of yellow fever, and that it is the duty of the general government to aid in the establishment of such a quarantine, and also to appoint a commission of experts to make investigation into the causes of yellow fever and the best methods of preventing its introduction; also the importance of internal sanitary measures, and urging State and municipal authorities to aid in preventing the introduction of yellow fever."

In the discussion of these propositions, Medical Inspector Albert L. Gihon, U.S.N., put on record the experience, and opinion based on that experience, of the medical officers of the Navy, whom he there represented by the authority of the Navy Department. He believed these to be the unanimous opinions of his colleagues in the Medical Corps.

First. The yellow fever ship is always a foul ship.

Second. Foul ships, while often generating by their filth other endemic diseases, have never yellow fever *de novo*.

Third. When a foul ship visits a port where yellow fever prevails, communication with that place will cause the development of yellow fever aboard that ship.

Fourth. A clean ship may visit a port in which yellow fever is prevalent, and by rigorously abstaining from communication of any kind with that port, will escape yellow fever contamination.

Fifth. When yellow fever appears on board a vessel, the only safety for the crew is to get them out of the ship.

Sixth. The sick can also be removed from the vessel with entire impunity to those among whom they are removed.

Seventh. Nurses and attendants upon the sick with yellow fever aboard ship are not more liable than other occupants of the vessel to contract yellow fever.

Eighth. When the yellow fever appears aboard a vessel, it is possible to imprison it by battening down the hatches, carefully caulking every possible outlet for emanation from the hold and lower decks, and by requiring the crew to live and sleep in the open air and spar deck, and abstaining from using food, water, clothing, &c., which has been below.

Ninth. If this vessel is removed to a place where bad sanitary conditions prevail, and any of its contents are discharged, it will inevitably disseminate yellow fever.

Tenth. It is believed that in places to leeward currents of air from such an infected vessel will cause the appearance of yellow fever in such places.

Eleventh. Freight, food, baggage, clothing, &c., cannot be safely removed from infected vessels until they have been exposed to the prolonged continuance of extreme cold weather.

Twelfth. No vessel on which yellow fever has prevailed can be safely re-inhabited until after such exposure.

Thirteenth. It is believed, but not entirely demonstrated, that permeation by dry, hot-air steam will destroy the germ of yellow fever.

In conclusion, "It is our belief that yellow fever is due to a specific living germ—the vitality of which may be impaired or destroyed by extreme cold, and which rapidly propagates itself when deposited in a nidus of visible or invisible filth."

Dr. Snow, of Rhode Island, offered the following, which was adopted:

"*Resolved*, That the heartfelt thanks of this Association and of the whole people of the country are due to Mrs. Elizabeth Thompson, of New York, and to other philanthropic individuals and associations who by their liberal contributions have enabled the Yellow Fever Commission to prosecute its investigations, and also to those who have been concerned in organizing the work of the Commission and in presenting the result of its work to this Association."

The following officers were elected for

the ensuing year: President, Professor J. L. Cabell, of the University of Virginia; Vice-Presidents, Dr. J. S. Billings, U.S.A.; Dr. Samuel Choppin, of New Orleans; Treasurer, Dr. Henry B. Baker, of Michigan; Dr. Edward S. Janes, the Secretary, holds over. The following Executive Committee was elected: Drs. C. B White, of Louisiana; T. J. Turner, U. S. N.; Ezra M. Hunt, New Jersey; J. D. Plunket, of Nashville, Tenn.; C. F. Folsom, of Massachusetts, and C. A. Hewitt, of Minnesota.

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Medical Society of Virginia.—The ninth annual session of this Society was held at Richmond October 22d, 23d, 24th, and 25th, Dr. John H. Claiborne, of Petersburg, President, in the chair. One hundred and twenty-eight Fellows were in attendance. The following officers were elected for the ensuing year: President, Levin S. Joynes, M.D, of Richmond; Vice-Presidents, Drs. Herbert Nash, of Norfolk; L B. Ward, of Smyth; W. P. McGuire, of Winchester; James C. Green, of Danville; and Gabriel McDonald, of Monroe; Secretary, Dr. Laudon B. Edwards, of Richmond.

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Surgeon-General of the Navy.—Surgeon J. WINTHROP TAYLOR has been appointed Surgeon-General of the Navy, *vice* Surgeon-General Grier, retired on account of age.

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OBITUARY RECORD.—Died, at Charleston, South Carolina, on the 12th of October, after a brief illness, ELI GEDDINGS, M.D., Professor of Surgery in the Medical College of the State of South Carolina, aged 79 years.

Dr. Geddings was born in Newberry, S. C., in 1799. He received a school and classical education, and read medicine in Abbeville, S. C., subsequently graduating in medicine in the Medical College of the State of South Carolina in 1825. Dr. Geddings was the pioneer in the South among those who deliver courses of public prelections upon anatomy, physiology, and operative surgery to classes independently of any chartered institution; and such were the success and popularity of his lectures, that numbers throughout the South still bear attestation to the elocutionary readiness, point, and condensation of his teachings even at that early period. A brief sojourn in Europe perfected him in his studies, while the acquisition of several of the modern languages, consorted with a colossal memory, gave him remarkable pre-eminence among many of his colleagues in almost every department of our profession.

Upon his return from Europe, he was appointed Demonstrator of Anatomy in the Medical College in Charleston, though he was soon called to the chair of Anatomy in the University of Maryland, and thence to New York, after which he again returned to Charleston, where he successively filled the chairs of surgery and practice of medicine, upon the death of Prof. Ramsay and resignation of Prof. Samuel H. Dickson and P. Gaillard.

While in Baltimore, Dr. Geddings edited the *North American Archives*, throughout the pages of which work may be found his various contributions to medicine and surgery. His active career as a surgeon supplied him with a collection, particularly of the diseases of bone and of surgical pathology, which now forms a conspicuous feature in the museum of the Medical College of Charleston; and furnished the periodicals of our country with publications of interest.

It has been the privilege of few to have enjoyed so wide a range of influence in any community, and to have exercised so large a share of usefulness during so long a period of professional activity as Prof. Geddings.

With a *physique* as vigorous as the mind was strong and brilliant which animated it, he was still engaged in counselling with and assisting his colleagues in every emergency to within a few days of his death.

FOREIGN INTELLIGENCE.

The Determination of the Cardiac Triangle.—Dr. CONSTANTINE PAUL proposes the following method in lieu of those at present in use, in order to determine the cardiac triangle. It is necessary to begin by precisely fixing the point corresponding to the apex of the heart; this point being found, its relation must be determined with the points of the thorax more fixed than it; the nipple will not serve as a landmark, by reason of the variability of its position in different individuals; it is necessary to designate the intercostal space at which the apex beats, and to measure the distance between the spot at which the pulsation is perceived and the medium line of the body. This done, the outer border of the liver is determined by percussion; and this line, which is a little below the real line, being extended to the region of the point of the apex, affords the indication of the right border of the heart. To obtain the right and inferior angle, the lung is percussed in the transverse sense, and the zone of dulness is reached which corresponds to the limit of the auricle. This method of insuring the extent of the cardiac triangle allows us, according to M. Paul, to easily define the changes in the size and position of the heart. He presents a series of observations on ventricular hypertrophy with schematic figures in support of his view.—*British Medical Journal*, Oct. 12, 1878.

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Solubility of Chloral in Fatty Bodies.—M. CATILLON (*Gaz. Hebdom.*, Nov. 1), in a communication to the Société de Thérapeutique, observed that the ready solubility of chloral in considerable proportions in fatty substances is not generally known, and may often prove of great utility in practice. One part of the hydrate is soluble in two of oil. The formula which he recommends is chloral 6 and oil of sweet almonds 30 parts; or chloral 6, lard 27, wax 3 parts. On the same principle, we may make plasters, bougies, or suppositories according to the following formula: chloral 1, white wax 2, and butter of cocoa 2½ parts.—*Medical Times and Gazette*, Nov. 9, 1878.

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Quantitative Test for Urea.—Dr. ARTHUR GAMGEE, Brackenbury Professor of Physiology at the Owens College, Manchester, has proposed a new and ready method of very accurately estimating the quantity of urea in urine, by means of a solution of sodium hypobromite. This solution, which is of a yellow colour, and can be easily prepared by simply pouring bromine into a solution of caustic soda, has the property common to solutions of the alkaline hypobromites, of decomposing urea into carbonic acid and nitrogen. The carbonic acid is absorbed by the alkaline solution, so that the gas which is given off, upon mixing with it a urea-containing liquid such as urine, consists wholly of nitrogen. By measuring therefore in a suitable apparatus, the quantity of gas (nitrogen) evolved on mixing a solution of the hypobromite with a known quantity of urine, the percentage of urea can be estimated with the utmost nicety.—*Medical Times and Gazette*, November 9, 1878.

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The Urine of the Insane.—M. ALBERT ROBIN (*Sociète de Biologie*, June 24th) had occasion to examine the urine of a madman who died at the Hospital Beaujon, and communicates the very interesting results of his researches. The quantity of the urine was diminished to 300 grammes in twenty-four hours; the specific gravity was 1030; the reaction acid, remaining so after exposure to the air for eight days. The amount of solids was 25 grammes in twenty-four hours, that of urea only 10.22 grammes, but uric acid, on the contrary, was present in large proportions. The chlorides were diminished, the phosphates normal; sugar and albumen were not present. In the sediment, after evaporation, he found crystals of the hippurate of calcium, margaric acid, leucine, and an enormous quantity of uric acid. Many bacteria of a special nature were found on microscopical examination. M. Robin asks whether it might be possible to inoculate madness by means of urine?—*British Medical Journal*, Oct. 12, 1878.

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Deaths from Chloroform.—The *British Medical Journal* (Oct. 12, 19, and Nov. 9, 1878) reports three cases.

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Personal.—Mr. LISTER has been gazetted Surgeon-Extraordinary to Her Majesty Queen Victoria.

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PROSPECTUS FOR 1879.

For the second year of the second half century of the "AMERICAN JOURNAL OF THE MEDICAL SCIENCES" the publisher has pleasure in announcing a continuance of the attractions of the JOURNAL and its adjuncts which, it is hoped, will render these periodicals, as heretofore, indispensable to every reading physician.

In the "MEDICAL NEWS" there will be continued the series of original American Clinical Lectures, of which the national character and practical interest have given so much satisfaction to subscribers during 1878, embracing elaborate lectures from Professors GROSS, THOMAS, PEPPER, SAYRE, BARTHOLOW, RICHARDSON, S. W. GROSS, PORCHER, GOODELL, DAVIS, and VAN BUREN. Those from whom contributions may be expected in 1879 are—

AUSTIN FLINT, M.D., Prof. Prin. and Prac. of Med., Bellevue Hosp. Med. Coll , N. Y.
FORDYCE BARKER, M D., Prof. Clin. Midwifery, &c., Bellevue Hosp. Med. Coll., N. Y.
L. A. DUHRING, M.D., Clin. Prof. of Diseases of the Skin, Univ. of Penna.
THEOPHILUS PARVIN, M.D., Prof. of Obstetrics, &c., Coll. Phys. and Surg., Indianapolis.
JOHN ASHHURST, Jr., M.D., Prof. Clin. Surg., Univ. of Penna.
D. WARREN BRICKELL, M.D., Prof. Obstetrics, &c., Charity Hosp. Med. Coll., N. O.
J. LEWIS SMITH, M.D., Clin. Lec. on Dis. of Children, Bellevue Hosp. Med. Coll., N. Y.
WILLIAM F. NORRIS, M.D., Clin. Prof. of Diseases of the Eye, Univ. of Penna.
P. S. CONNER, M.D., Prof. of Anatomy and Clinical Surgery, Med. Coll. of Ohio.
THOMAS G. MORTON, M.D., Surgeon to Penna. Hospital.
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THE

MEDICAL NEWS.

MDCCCLXXIX.

VOL. XXXVII.

PHILADELPHIA:
HENRY C. LEA.
1879.

PHILADELPHIA
COLLINS', PRINTER

THE MEDICAL NEWS AND LIBRARY.

VOL. XXXVII. JANUARY, 1879. No. 433.

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CLINICAL LECTURES.

ON THE DIAGNOSIS OF PREGNANCY.

Delivered at the City Hospital, Indianapolis.

BY THEOPHILUS PARVIN, M.D.,
of Indianapolis, Indiana.

GENTLEMEN: Two patients, who will be presented in a few minutes, give us an opportunity of studying some of the signs of pregnancy. The diagnosis of this condition may be of such importance for the welfare of others and for your own reputation, and is sometimes beset with such difficulties, that you can never regret a faithful study of the signs which by their presence prove, or by their absence disprove it. This diagnosis is oftentimes of vast importance as to a patient's physical good—nay, her life itself may depend upon your reaching a just conclusion. Or, again, you may rescue some unfortunate girl, by an early recognition of her pregnant condition, from public exposure, secure her by marriage the imperfect but only possible reparation for the great wrong done her by her seducer, and thus, too, save their offspring from the brand of a bastard. In another case, where the abdomen is enlarged by ovarian, uterine, or other tumour, or from the menstrual accumulation consequent upon an imperforate hymen, you may, by establishing the fact that the subject is not pregnant, rescue her name from the reproaches of busy tongues, and relieve her of a sorrow worse than death.

The history of medicine has numerous illustrations of grievous errors of diagnosis; errors that sometimes brought fatal results. Happy is the physician who

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never made a mistake in this regard—on the one hand denying a pregnancy when it really existed, or alleging it when it did not.

English history has two remarkable illustrations of imagined pregnancy, doctors themselves consenting to or believing in the delusion. An English queen of the sixteenth century, one whose brief reign of cruel persecution gave her name a horrible title, believed herself pregnant, felt the motions of her child, doctors agreeing to the fact, and she made all preparations for her parturition. "Not only was the child assuredly coming, but its sex was decided on, and circulars were drawn and signed both by the king and queen, with blanks only for the month and day, announcing to ministers of state, to ambassadors, and to foreign sovereigns the birth of a son." Prayers were offered in churches for the coming prince, and a nation was ready to break forth in joy at the event. But the prince came not; for there was no pregnancy, and the abdominal enlargement which was the chief foundation for belief in it was pathological, not physiological. I do not remember to have ever seen any discussion as to what the character of this enlargement was in the case of Queen Mary, but if I interpret correctly the picture that Froude has drawn of this unhappy woman at that time, and remembering that she lived less than two years and a half after, her malady was ovarian dropsy.

Joanna Southcott, who from ignorance, poverty, and obscurity, rose to be the religious leader of thousands, when upwards of sixty years of age declared herself to be pregnant with a new Shiloh, and her physician agreed in her belief as to pregnancy. The miraculous conception was only in her mind, and ascites was the cause of her abdominal enlargement.

The story of the English queen and of the English prophetess is often repeated; women thinking themselves pregnant chiefly because they intensely desire to be so. Now such desire, such mental influence may produce some of the subjective signs of pregnancy.

On the other hand, the fear of pregnancy may also cause some of these signs. Girl or woman lapses in some hour of temptation, lapses once only, as she says, and when her next monthly period is due, anxiously looks for it, but this very anxiety defeats or delays its coming.

Still more, the physician has other cases different from these subjected to his inquiry; cases of real pregnancy, but where every effort is made to conceal the fact, and false answers are given that may mislead him should he trust merely or mainly to the subjective evidences. Many a girl will not yield up the secret of her ruin even in the agonies of parturition or in the article of death itself.

In the investigation of cases of suspected pregnancy, especially when there are moral reasons for this pregnancy not existing, the party being unmarried and occupying high social or even religious position, you must especially seek a judicial condition of mind. You will lay aside all prejudice, all passion, and, for the time, all sympathy, but still always be kind and gentle; you must be, as a great novelist has described the medical character in a sick-room, "a Calm Intelligence;" the subject submitted you is simply a woman, no more, no less than any other daughter of the great human family.

Having made these preliminary remarks, let us now consider the condition of these patients. Both of them are in the child-bearing period of life, and so far we have a possibility. Each believes she is pregnant, but that amounts to little in determining your conclusion. It is not what their tongues tell you, but what your eyes can see, your hand handle, or finger touch, and your ear hear; in a word, the *objective*, not the *subjective* signs that will guide you infallibly.

The first patient, who was sent to the hospital as being pregnant, tells us that her menstruation has been absent six months, that she has almost incessant nausea and vomiting, and that there is a notable increase in size of the abdomen. I have no reason to doubt her statements, especially as they are in part confirmed by one of the resident physicians.

But let us now turn to some of the objective signs, and see if they confirm or contradict the pregnancy which undoubtedly is strongly suggested by her statements. Upon observation you will notice that the mammary gland is not large, not full and tense, but the areola about the nipple is quite dark and much more distinct than in the virgin. This woman, I ought to have told you before, was pregnant some year or two ago and gave birth to a child. There is less significance, therefore, in this areolar pigmentation, when a woman has previously had one or more children. So, too, you will find a pigmentation quite equal to that observed in this patient, in many cases of ovarian tumours; but in those cases as in this, you generally find, when the disease has continued for any length of time, the breasts are quite flaccid.

Let us now examine the abdomen, which the patient states has increased in size since the cessation of menstruation. You can see its outlines through the covering as she is lying upon her back, and it does seem fuller, more prominent. But try percussion, and you will find nothing but tympanitic distension. Try palpation, and you can find no tumour, no defined swelling, still less such enlargement as the gravid uterus would present at five or six months. It is not necessary, it is not possible, to resort to the great test, the most valuable of all means of diagnosis in cases of supposed pregnancy, in this case, for there is no uterine tumour to auscult.

Let us pass to the second patient; she has one of the most important subjective symptoms, menstrual suppression, that the first had. But without delaying for such signs, I beg you to look at once at the mammary gland, and see what a contrast in prominence, size, and firmness. Especially notice the deep hue and extent of the areola—a dark-brown circle nearly two inches in diameter, from the centre of which the nipple stands out cylindrical in form, turgid and prominent. Now, outside of the dark-brown ring, there is a secondary areola much paler, and flaked with whitish spots that might be imitated in appearance by a piece of dirty, dingy paper upon which drops of water had fallen here and there. But turn your attention again to the primitive areola, and you will see the evenness of its surface broken by little tubercular-like elevations, sixteen can be counted in this case, standing out very prominently. These papillary tubercles, which are really, so far as it concerns structure and secretion, when secretion occurs, miniature mammary glands, are equally responsive to the stimulus of pregnancy. Furthermore, eye and finger will recognize a swollen condition of the areola, apparent œdematous puffiness, which is probably the expression of increased vascular supply rather than increase of tissue.

These then are the three mammary signs of pregnancy of the greatest importance—areolar pigmentation, development of papillary tubercles, and areolar turgescence. These changes are noticed as early as the third month, but to see them in their complete evolution, as they are shown in this case, a much later period of pregnancy must have been reached; for example, the secondary areola, which Montgomery (in his classic work on the Signs of Pregnancy, a work every doctor should have) declares, "constitutes a strikingly distinctive character, *exclusively resulting from pregnancy*," is not seen earlier than the fifth month.

At any rate you would hardly be willing to declare upon your oath that pregnancy existed even when you had these and the other mammary signs of such condition, viz., the swollen, painful condition of the glands, and the secretion of milk; still less in the absence or the partial presence of one or more of these, would you be willing to testify that she was not pregnant, when we have available means in which error is exceptional, and the conclusion almost infallible, means that are at once simple and easy of application. You can easily imagine I refer to the stethoscope and auscultation. More than one recent text-book on obstetrics teaches that examination of the breasts is less repulsive than auscultation of the abdomen. So it is if the latter be done with the naked ear, and upon the naked abdomen, a way that is as indecent as it is unsatisfactory and misleading. A modest woman will shrink from exposing her breasts to your gaze and touch, but will not seriously object to the stethoscope applied to the walls of the abdomen covered with chemise or sheet. So, too, one who is trying to conceal her pregnancy, will have her suspicions aroused, and may refuse the former, while she does not distrust the latter, sees no danger of discovery in a wooden tube, and makes no resistance to its application.

Laennec declared that obstetric auscultation was more difficult than auscultation of the chest. That may be true so far as the finer revelations thus obtained are concerned, but so far as it relates to the grosser—the detection of the fœtal-heart sounds at five months and after, and the subjects examined being favourable ones—no masking of those sounds by abdominal fat, for example, I think it altogether too absolute.

I need not tell you that obstetric auscultation is one of the triumphs of the present century, for auscultation of the chest was not known to the profession until soon after the year 1816, that being the year in which Laennec devised the stethoscope. About the close of the seventeenth century a distinguished Italian physician sadly exclaimed, How difficult it is to cure diseases of the lungs! How much more difficult to recognize them! More than a hundred years passed before this difficulty of diagnosis was removed. In 1819 Laennec's treatise upon *Mediate Auscultation* was published, and in a short time afterward, two observers, working independently of each other, discovered that upon examining with the ear the abdomen of a pregnant woman, the fœtal heart-sounds could be heard. Now this discovery was with each observer not only independent but accidental—neither was listening for what he heard. One of them, Mayor of Geneva, was listening for *bruits* or sounds caused by the movements of the fœtus; the other, Kergaradec, for the *bruits* resulting in the amniotic liquor from such movements. Other sciences than Medicine are indebted to accident, or chance if you please, for some most important discoveries. Many of these will occur to your own minds; Jevons[1] gives some interesting illustrations, and in referring to the subject he remarks, "Accident may bring a new and valuable combination to the notice of a person who has never expressly searched for a discovery of the kind, and the probabilities are certainly in favour of a discovery being occasionally made in this manner. But the greater the tact and industry with which a physicist applies himself to the study of nature, the greater is the probability that he will meet with fortunate accidents, and turn them to good account."

Mayor and Kergaradec met with a fortunate accident, and turned it to good account. Kergaradec not only recognized the pulsation of the fœtal heart, but also a *souffle* which he attributed to the place of attachment of the placenta, and which was for some time called the *placental souffle*, a designation which perpetuates an error, and is therefore mischievous: its proper designation is the *uterine souffle.*

Other sounds beside these may be heard in obstetric auscultation, but to these two the examination will be limited.

Now with the abdomen smoothly covered by a sheet, an abdomen which you will observe is very prominent, has the size, and to palpation reveals a distinct tumour, the shape and the density of the uterus at seven to eight months' pregnancy, let us apply the stethoscope. But where? The uterine souffle is usually heard most distinctly upon the sides of the uterus. Here let me call your attention to two apparently contradictory statements made by Montgomery in the work already referred to. After stating that the sound is most frequently recognized upon the lateral regions of the uterus; a few paragraphs further on, in referring to the sound, he remarks, "I believe it to have its origin in that part of the vascular apparatus of the uterus most immediately connected with the placenta; and that in almost all cases, if the situation of this latter organ be accessible to the stethoscope, we shall then almost certainly hear the souffle." But surely the placenta is not usually attached to the side of the uterus, and, therefore, this uterine souffle cannot be connected with the placenta. I might go on to say, as still further establishing the non-dependence of the souffle upon the placenta, that it is heard after the detachment of the placenta; heard too in other than physiological enlargement of the uterus, as for example, in uterine fibroids. This last fact, therefore, shows you that if you do hear it, you have no conclusive evidence of pregnancy. The sound itself, as may be observed in this case most distinctly on the left side, is a soft murmur, wave-like in recurrence, and isochronous with the mother's pulse, but not a pulse, no beat, no shock.

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[1] The Principles of Science.

Not many months ago a contributor to a foreign medical journal asserted that he could determine in advance the sex of a child, by ascertaining the position of the placenta. If the placenta was attached to the left side of the fundus, the child was a female; if to the right, a male; in other words, the boys come from the right ovary, the girls from the left! He declares, "I have listened with the stethoscope before birth, and have ascertained the position of the placenta by the *bruit*, and have settled in my mind the sex of the child, a fact which has afterwards been verified at its birth." But if what I have said to you be correct, if the highest obstetric authorities are not in error, this ingenious speculator is greatly at fault—he builds his theory upon a false fact, and of course it amounts to nothing. Schrœder says positively that no safe conclusion as to the seat of the placenta can be drawn from this *bruit*.

Notwithstanding the essential error in and the absurdity of the theory, the paper containing it has been republished in this country without criticism or comment as if it were true!

This wonderful physiological fact, that males come from the right, females from the left ovary, ought not to be communicated to the gallinaceous order, since in this only the left ovary is developed, and consequently there ought, for example, to be no more roosters. But there are some of the feathered tribe who have two ovaries, and therefore are competent to produce both male and female—geese, for example: by all means, then, let the geese have this important information, and let them believe it!

This uterine souffle—it is to be hoped all observers will soon fail to hear the placental souffle, and cease to talk or write of it—may generally be heard early in the fourth month; and, according to Depaul, increases in distinctness up to the seventh or eighth month, when it remains without change to the termination of pregnancy.

But as has already been stated this sound is not a proof of pregnancy. Hearing it after you have heard the sounds of the fœtal heart, you have corroboration; hearing it before, you have merely hint and encouragement to seek them as final evidence.

Let me say a word in explanation of the fact that in this case the uterine souffle is heard more distinctly upon the left side. There is very decided, as in most cases of pregnancy, right obliquity of the womb; and connected with this change, in the latter months of pregnancy, there is, according to Depaul, such *torsion* of the uterus that usually its left side is thrown more in front, and, therefore, is more accessible to stethoscopic examination, while the right side is more hidden, less exposed to such examination.

Proceeding to our examination for the sounds of the heart, where shall the stethoscope be applied, where shall we listen? If this patient were in the fourth or fifth instead of the eighth, as she is supposed to be, month of pregnancy, the stethoscope would be placed upon the hypogastric region, in the median line and in the axis of the superior strait, for only there and then could we hope to get near enough to the fœtus to hear its heart sounds. Up to seven months the fœtus is quite mobile in the uterine cavity; that cavity being nearly spheroidal, the relative quantity of liquor amnii being great, the position which the fœtus occupies is indifferent, and, therefore, variable, changes from one time to another. Under such circumstances, the place where the sounds of the fœtal heart are best heard may vary in different examinations. But with the increased growth of the fœtus, and the uterus assuming an ovoidal form, the previous facility of motion is lost, and the fœtal ovoid comes to correspond with the uterine ovoid. In ninety-six per cent. the cephalic extremity of the ovoid is below, and in a very large proportion of these cases the occiput is upon the left side of the mother's pelvis. Now imagine a line drawn from the left anterior superior spinous process of the ilium to the umbilicus, about the middle of that line is the place where in the vast majority of cases of pregnancy this far advanced, you would expect to hear most distinctly the fœtal heart sounds. Failing there, a corresponding point upon the right side is next selected; and here in this case I find the sounds most distinct. I want a few of you to listen to them; not many, because I remember a similar examination in which more than a dozen students participated, and premature labour occurred within twenty-four hours. Once having heard this sound, you will surely recognize it again; you can hardly confound it with another. Let me qualify those last words. Never be sure you hear the fœtal heart until you have counted the mother's pulse, and found that the two are not isochronous; error is possible if you neglect such comparison. Pajot has recorded a case where such an error was committed by one of the most eminent of French obstetricians, one, too, who had given much study to obstetric auscultation—Dubois. In a case where there was some pelvic deformity, this illustrious teacher stated that having heard the fœtal heart he would first try to deliver with the forceps rather than with the cephalotribe. Some physician listened, and they also heard the sounds; so did Pajot. The forceps were used, and a child at full term delivered, dead several days, and even macerated. That mistake could not have been made if the mother's pulse had also been examined and compared as to time and frequency with the supposed pulsation of the fœtal heart. Let the history of this error prevent a similar one occurring to any of you.

If we had failed in hearing the sounds at either of the points mentioned, we would then seek them at one of two points a little above, one to the right, the other to the left of the umbilicus. When you thus hear the sounds at the upper part of the uterine ovoid, or hearing them below, hear them above most distinctly, your conclusion is that the pelvic extremity of the fœtal ovoid is presenting, and its cephalic portion is at the fundus. The comparison usually made of these sounds to the *tic-tac* of a watch under your pillow, while the side of your head is resting upon that pillow, is as correct as any that can be made. You may say roughly that the interval between the *tic* and the *tac* is about half that between two *tic-tacs*. So, too, the *tac*, the second sound, is fainter than the *tic*, the first sound. I need not add anything to this description; those of you who have heard the sonuds will recognize its general correctness.

The average frequency of these heart-sounds is one hundred and forty per minute. Depaul, in two hundred and twenty pregnant women examined, found the maximum one hundred and sixty, and the minimum one hundred and twenty, so that the mean is one hundred and forty.

Having heard these sounds distinctly in a given case, having carefully avoided all sources of error, especially that which might arise from the quickened pulsations of the possibly anxious woman, you are sure, in spite of all contradiction of words, of other signs, and of surrounding circumstances, that pregnancy exists—sure, too, that the child is living.

Now although the pulsations of the fœtal heart may be heard in the fourth month—in twelve cases out of sixteen they were recognized by Depaul at the expiration of the third—yet it is not until the fifth month, and towards its termination that they are available for most observers.

Depaul states that out of nine hundred and six women examined in the last four months of pregnancy, he failed to hear the sounds of the fœtal heart but eight times.

You see, then, how available and valuable this sign of pregnancy is. Unfortunately most of our text-books on obstetrics devote little space to auscultation. Not only in the diagnosis of pregnancy, but also of presentation and of position, and in the conduct of labour, is the stethoscope of great utility and of unspeakable value. By it, too, the diagnosis of twin pregnancy has frequently been made; in one case Nægele thus detected the presence of three infants in the uterine cavity.

At the commencement of my attendance upon medical lectures, the late Dr. Samuel Jackson, one of the most brilliant lecturers and eloquent teachers the grand old University of Pennsylvania ever had, observed to me, "Never miss an opportunity of seeing a sick person." If I were to embody in language to you similar advice as to the subject that has engaged us, it would be, never miss an opportunity of using the stethoscope in a case of pregnancy.

HOSPITAL NOTES AND GLEANINGS.

Cerebral Localization illustrated by Injury of the Head.—Prof. Broca read a case to the Académie de Médecine (*Gaz. Méd*, Nov. 16) on the part of Prof. Obé, of Bordeaux, bearing the following title: Fracture of the Cranium—Considerable Depression of the Occipital Bone opposite to and below the Parieto-Occipital Suture; the depression reached the upper curved line of the occiput—Disorders in motor power and language and disturbance of vision—Cure, with restoration of the lost faculties, verified two years and a half after the accident. This case, Prof. Broca observed, which is of great interest in regard to cerebral localization, occurred in the person of a railway *employé*, whose head was struck on the left side against an obstacle during the passage of a train. Loss of consciousness continued for several days, and disturbances of locomotion were observed on the right side. After some time, on trying to speak, he found that he could only speak the *patois* of his native town; and it was only at a later period that he was able again to speak French, which he had been for years in the habit of speaking. The difficulties of locomotion and speech gradually disappeared, leaving him with only some derangement in the motions of the left eye (preventing him, for example, following the movements of the telegraphic needle, and obliging him to desist from this portion of his employment). The depression existed just at the point corresponding to the centre of the movements of the eyes, as indicated by Ferrier and other physiologists.—*Med. Times and Gaz.*, Nov. 30, 1878.

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Pyelitis caused by a Calculus in the Ureter, and associated with Perinephritic Abscess.—A house-painter, aged forty-six, was admitted, August 1st, 1878, into Dr. Philipson's ward at the Newcastle-upon-Tyne Infirmary. He stated that he had been ill for three months, and that for two months he had suffered from pain in the abdomen, more especially in the left side, and round the back. The pain was relieved by vomiting. The bowels were much constipated. The blue line on the gums was well marked. He was frequently troubled with cramps in the legs and arms. The urine was small in quantity, of sp. gr. 1010, neutral in action, and was free from albumen.

The symptoms were regarded as due to the effect of lead in the system, and he was prescribed the sulphate of magnesia, with the dilute sulphuric acid, three times each day. This treatment was continued to August 17th, with the effect of rendering the bowels free, and of mitigating the pain in the abdomen. The iodide of potassium, in doses of ten grains three times each day, was commenced.

From time to time he complained greatly of the pain in the left loin, and said it was burning and grinding in character, and that some nights he was unable to sleep in consequence of its severity. Relief was obtained from the subcutaneous injection of morphia and the application of the belladonna and choloroform liniment.

On September 21st, after a careful examination, a hardness was detected between the crest of the left ilium and the lowest rib, which was regarded as due to perinephritis. Warm anodyne fomentations were ordered.

25*th*. Has suffered from repeated retching, and has been unable to take food. Has emaciated considerably. Towards evening hectic flushings occur. Has not had any rigours. The tenderness and fulness in the left loin have increased. Fluctuation has not been detected. There is no expansion in front to justify the supposition of renal tumour. The urine has continued free from albumen. Under the microscope neither blood, pus, nor epithelium from the pelvis of the kidneys has been recognized.

The irritation and pain continued, and he died exhausted on October 4th.

Necropsy, twenty-three hours after death.—The body was much emaciated. On opening the abdomen, the liver was seen to project considerably below the ribs, both the right and the left lobes being considerably enlarged. It weighed 5¼ lbs., and was paler than natural, the capsule being firm and tense. On section, the surface was smooth, and was deeply stained by a strong solution of iodine. The spleen was firmly adherent posteriorly, weighed four ounces, and was normal in appearance. The peritoneum was natural. The left kidney was firmly adherent to all the surrounding structures. The whole of the kidney substance was destroyed, its place being taken by thick pus; the capsule was thickened and was adherent to the neighbouring tissue, which was cartilaginous in consistence. Between the exterior of the left kidney and the lumbar muscles was a large collection of pus. The pelvis of the left kidney contained a calculus, measuring fully one inch in length and half an inch in breadth. It was curved at one extremity. The calculus was firmly fixed in the ureter. The calculus was smooth on the surface, and friable, and was composed of phosphates. The bladder was firmly contracted; its walls were thickened, and its internal surface was somewhat congested. The bladder contained no calculus. The right kidney weighed five ounces; externally it was slightly irregular; its surface was abnormally pale, and it was slightly waxy, the Malpighian bodies being stained with iodine. The right ureter was healthy. The stomach was congested; its mucous surface was stained with bile. The intestines were healthy. The heart weighed ten ounces; its cavities were filled with clots; its valves were healthy. The right lung weighed twenty ounces, the left fourteen ounces; both were healthy. The brain weighed 2 lb. 7½ oz.; externally it was normal, as also internally.

Remarks by Dr. PHILLIPSON.—The interest of this case is the association of the pyelitis with the perinephritis, the ill-defined symptoms and indications of these conditions and of calculus in the kidney, and the extent of the kidney lesion, as revealed by the necropsy.

The symptoms of pyelitis are, in part, those produced by the morbid state exciting it, especially those denoting a calculus lodged in the kidney, or arrested in its transit towards the bladder; partly those directly traceable to the inflammation of the pelvis and the infundibula. The manifestations of the latter disorder are constant pain in the loin, felt also in the course of the ureter, and the passage of pus and occasionally of blood in the urine. With the exception of the pain in the left loin, all the distinctive symptoms were absent. The absence, however, of albumen, pus, or blood in the urine is explained by the condition found after death, namely, the obstruction of the left ureter by the calculus.

The history of the case, more especially the occupation of the man, that of a house painter, the presence of the blue line on the gums, and the abdominal location of the pain, pointed to lead impregnation as the cause of the symptoms; hence the treatment that was adopted.

The supervention of slow inflammation in the tissues surrounding the left kidney was correctly diagnosed, but there was uncertainty as to its passage into suppuration, on account of the absence of any rigor and deep fluctuation. The character of the calculus is of interest, namely, that it was composed of phosphates; for, from recorded cases, stones in the kidney are most frequently composed of uric acid, more rarely of oxalate of lime, and still less often of phosphates.

The right kidney was enlarged, and was comparatively sound in structure. It exemplified that kind of compensation when, of double organs, one has been rendered incapable of its natural functions, and the other has taken up its duty and performed a twofold amount of work.

The commencing waxy condition of the right kidney, and the more advanced state of the liver, are explicable from the prolongation of the illness, and the association of this with the protracted irritation and hectic fever, such a general condition being regarded as the cause of this structural state.—*Lancet*, Nov. 30, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Viburnum Prunifolium.—At a late meeting of the Obstetrical Society of Boston (*Boston Med. and Surg. Journ*, Nov. 14, 1878), Dr. ABBOT spoke of a remedy which he had lately employed with much satisfaction in dysmenorrhœa. It was well known, he said, that a secret remedy, called "Hayden's viburnum compound," had considerable reputation in these cases. The viburnum prunifolium has long been regarded as having a special action upon the uterus. Being unwilling to use the secret remedy, he experimented with a fluid extract of viburnum, manufactured by Burrough Bros., of Baltimore, with very satisfactory results. He had used it in six successive cases within the past two months, with entire relief in every instance. In one case there was not a particle of pain after the first dose. He had given a teaspoonful every second hour until relief was afforded, and it had required from two to six doses. To some patients the taste is not very agreeable, but this can easily be remedied by the addition of some aromatic. He thought it would be well to begin with the dose of two teaspoonfuls in an urgent case, and follow it up by teaspoonful doses every hour until the pain is relieved. [Dr. Abbot's experience subsequent to this meeting confirms thus far his favourable impression of this drug.]

Dr. CURTIS added his testimony in four cases, two in single women, one in a married sterile woman, and one in a woman who had borne two children. All got the greatest relief, the last one in particular, in whom he had previously tried everything, including morphia. Two doses gave entire relief. Metcalf's preparation has four times the strength of that of Hayden.

Dr. LYMAN reported four cases in which he had tried the remedy; one patient said she was somewhat relieved, one that she was entirely relieved, while the other two were not certain that they had been benefited in any degree. He began the administration one week before the expected flow. The plant from which the extract is made is viburnum prunifolium.

Dr. CHADWICK stated that he had made extensive use of the drug, chiefly in spasmodic dysmenorrhœa, and had obtained relief in many cases. It seemed to act as well as, but no better than, valerianate of zinc. In his dispensary it had been administered to fully fifty patients, with a large percentage of good results, but not so invariably successful or brilliant as those just announced.

Boston Medical Library Association.—On the evening of December 3d, the new building of this Association, situated at No. 19 Bolyston Place, was dedicated in the presence of a large audience. Addresses were delivered by Dr. Oliver Wendell Holmes, Dr. J. S. Billings, Mr. Justin Winsor, President Eliot, Dr. H. I. Bowditch, and others.

The new building, No. 19 Boylston Place, the ground lot of which measures 60 by 27½ feet, was purchased by the Association, and has upon it a mortage of $8000; there is also now due a debt of $4000. For the library, which has been collected within the last four years, and for the new medical hall, the Library Association and the profession in Boston are largely indebted to the energy, courage, and perseverance of Dr. James R. Chadwick, the Librarian of the Association.

The officers of the Association are: President, Dr. Oliver Wendell Holmes; Vice-President, Dr. Henry I. Bowditch; Secretary, Dr. Oliver F. Wadsworth; Librarian, Dr. James R. Chadwick; Assistant Librarian, Dr. Edward H. Brigham.

Index Medicus.—Mr. F. Leypoldt, 37 Park Row, New York, announces the publication this month of the first number of the "Index Medicus, a Monthly Classified Record of the Current Medical Literature of the World. Compiled under the supervision of Dr. John S. Billings, Surgeon U. S. Army, and Dr. Robert Fletcher, M. R. C. S. Eng." The prospectus states that "the Index Medicus will record the titles of all new publications in Medicine, Surgery, and the Collateral Branches, received during the preceding month. These will be classed under subject headings, and will be followed by the titles of valuable original articles upon the same subject, found during the like period, in medical journals and transactions of medical societies. The periodicals thus indexed will comprise all current medical journals and transactions of value, so far as they can be obtained. At the close of each yearly volume a double index of authors and subjects will be added, forming a complete bibliography of medicine for the preceding year."

As compiler of the Subject Catalogue of the Library of the Surgeon-General's Office Dr. Billings has gained an unrivalled experience in this kind of work, and his name as editor of the *Index Medicus* is a guarantee of the ability and care with which it will be conducted and of the fidelity with which the plan, as sketched, will be carried out.

The utility of the work is too evident to require demonstration; it is sufficient to say that it will give the titles, *arranged by subjects*, of all articles, whether in journals, transactions, etc., or in monographs or treatises, which have been recently published in any part of the world. It will also form a supplement to date of the Subject Catalogue of the Library of the Surgeon-General's Office, the publication of which it is hoped Congress will immediately authorize. We unhesitatingly predict that its value to every student, teacher, and writer in the profession will be incalculable and far beyond the meagre subscription price of three dollars a year.

Dr. Billings has again courageously undertaken a labour of love, and again lays the profession under deep obligations to himself, which we hope will be immediately acknowledged by numerous subscriptions to the *Index Medicus*, without which its maintenance is impossible.

FOREIGN INTELLIGENCE.

Dyspepsia.—At a recent meeting of the Medical Society of London, Dr. Leared read a paper on "A Neglected Proximate Cause of Dyspepsia," in which he argued that in a large proportion of dyspeptic cases the fault does not lie with the gastric juice *per se*, but with the muscular structure of the stomach. He considers that, owing to nervous debility, the peristaltic movements of the organ are either more or less diminished, or even arrested. The result is that the food, not being duly submitted to the action of its solvent, in part ferments, and the gas evolved distends the stomach. The distension tends to impair the tonicity of the muscular fibres still more, so that in some cases the stomach may be said to be paralyzed. The remarkable way in which stirring aids the solution of soluble substances in water was adduced by the author in proof of his position. Although the revolution of the morsels of food had been graphically described by Dr. Beaumont from actual inspection, he had failed to grasp their importance in relation to pathology. Instead of the old division of (1) atonic dyspepsia, and (2) dyspepsia from gastritis, Dr. Leared proposed to divide the subject into (1) dyspepsia from impaired motion, and (2) dyspepsia from defects of secretion; and he maintained that by further subdivision all varieties of true functional dyspepsia might be ranged under these two heads. The difference in origin of the proximate cause was also pointed out, and the treatment of impaired peristalsis was explained at some length. Diet was held to be of the greatest importance, and amongst medicines strychnia was placed foremost. This drug, properly handled, the author alleged to be almost a specific for relaxation of the gastric muscular fibres —*Med. Times and Gazette*, Dec. 7, 1878.

Tracheotomy in the Convalescence of Typhoid Fever.—After narrating (*Recueil de Med. Mil.* August) a case in full detail, Dr.

Poignard, a military surgeon, arrives at the following conclusions: 1. Deep-seated lesions of the larynx not infrequently complicate bad typhoid fevers. This laryngitis usually reveals itself at a late period by sudden and menancing symptoms. It is usually misunderstood at this period, its progress is insidious, and its prognosis is always very unfavourable. 2. Attacks of dyspnœa occurring during the course or convalescence of typhoid should at once give rise to a suspicion of œdema of the glottis, this being the ultimate symptom of deep-seated laryngitis in typhoid. 3. The diagnosis is sometimes very difficult, and the application of the laryngoscope is often impossible or dangerous. 4. The lesions produced are deep ulcerations, perichondritis, and necrosis of the cartilages, the cricoid being the most frequently affected, which explains the relative frequency of intra-laryngeal œdema without infiltration of the upper part of the larynx. 5. Change of voice during the existence of angina ought to lead to fear of the eventful occurrence of this laryngitis. 6. In presence of œdema too much reliance must not be placed on topical remedies. Tracheotomy is indicated when the dyspnœa is intense, or when suffocative paroxysms become long and frequent. We should never wait for imminent asphyxia, it being better to interfere at the early stage, especially in very debilitated subjects. Very advanced asphyxia, syncope, or abundant hemorrhage must not cause the operator to hesitate or desist. Tracheotomy has several times been performed in laryngitis with necrosis, and the results, which at first were but little encouraging, have of late become more and more favourable. Sometimes a persisting stenosis remains, obliging the patient to wear a permanent canula, constituting an infirmity with an unfavourable prognosis, but not militating against tracheotomy.—*Med. Times and Gaz.*, Nov. 30, 1878.

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Phthisis ab Hæmoptoë.—A valuable contribution to the debated question, whether hæmoptysis *per se* is an exciting cause of phthisis, is contained in a paper by Dr. Sokolowski, of Gorbersdorf (*Berl. Klin. Wochenschrift*, No. 39, 1878). He reports eight cases observed by himself, in which perfectly healthy individuals, living under good sanitary conditions, and abundantly supplied with the necessaries of life, were attacked with hæmoptysis without any preceding cough or phthisical symptom whatever. In all the cases some mechanical exertion or injury was the cause of the hemorrhage. In one carrying heavy logs of wood, in another prolonged singing in a hot and crowded room, in a third a fall from a horse, were the accidents which were immediately followed by hæmoptysis. The youngest patient was twenty-seven, and the eldest forty, ages which deviate from the ordinary time of onset of phthisis, for only the youngest patient, just referred to, was under thirty. Hereditary influence could only be traced, and that not decidedly in one instance. All the patients were males. The symptoms following the hæmoptysis were in four cases high fever, cough, dyspnœa, and expectoration, commencing within a few days; in the other four they were less acute, and assumed from the first a chronic type. Those also which were at first acute soon lost their febrile aspect. In three of the cases the hæmoptysis recurred after a time. The symptom which appeared the earliest, and remained the longest was cough. Only one case died, about six years after the injury which gave rise to the hæmoptysis. This patient was the one in whose family a phthisical tendency was suspected. The physical examination of the chest in all the cases revealed consolidation of one apex, and the usual auscultatory signs. One case is especially interesting, because the patient had been carefully examined by Dr. Sokolowski, about three years before, in the course of some spirometrical observations which he was engaged on, and his vital capacity was found to be 4200 cubic centimetres, his lungs and heart being perfectly healthy. The moral drawn by the author from his cases is that patients in whom hæmoptysis has succeeded exertion are not to return to their former occupation until all subacute chest symptoms have completely disappeared.—*Med. Times and Gaz.*, Nov. 30, 1878.

Employment of Carbolic Acid by Midwives.—The instructions for midwives in the Tyrol having been revised (*Allg. Wien. Med. Ziet.*, Nov. 12), the following directions have been added with respect to carbolic acid. The decree states that recent scientific investigations having proved that the much dreaded puerperal fever is an infectious disease that may be conveyed by the hands or by instruments which have not been properly disinfected, it is ordered that all midwives, whether examining or treating the healthy or sick pregnant or lying-in women, thoroughly disinfect their hands or any instruments they may use—such as catheters, enema-tubes, sponges, etc. For this purpose every midwife, when she visits a patient, must take with her a 5 per cent. solution of carbolic acid; and this, when she uses it for the above purposes, she must dilute in the proportion of one part to four parts of water.—*Med. Times and Gaz.*, Dec. 7, 1878.

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The Thermo-Cautery for Erectile Tumours.— M. **Fochier**, Surgeon to the Charité at Lyons, after narrating (*Lyon Méd.*, Dec. 1) some examples of the employment of the thermo-cautery, concludes with these words: "These facts appear to me calculated to demonstrate that in future the use of the thermo-cautery will prove the best method for the radical cure of erectile tumours. It is an instrument which is obligatory when dealing with deep seated tumours, and is more simple and its use less painful than that of the ligature or cauterization for superficial tumours. The operation of course is performed during anæsthesia. It is an instrument enabling us to deal with angiomas hitherto only amenable to a palliative treatment; as, for example, deep-seated erectile tumour of the parotidean region. In the absence of very special indications it should then be preferred for the treatment of all erectile tumours.—*Med. Times and Gazette*, Dec. 7, 1878.

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The Excretion of Carbonic Acid in Fever.—**Leyden** and **Fraenkel** have made a series of experiments on the secretion of carbonic acid in the febrile state. The observations were made on dogs, and the amount of carbonic acid exhaled was estimated with one of the smaller apparatuses of Pettenkoffer, large enough, however, to receive a dog weighing twenty to forty kilogrammes. With this the excretion of carbonic acid during abstinence from food was first estimated in each case over a period of several days, and then pyrexia was induced by the injection of fresh pus into the muscular tissue of the thigh. Although not very uniform in its effects, this method several times caused an elevation of temperature of from two to three and a half degrees Centigrade. Seven such series of experiments were carried on. The amount of carbonic acid exhaled was found to diminish constantly, although not rapidly, during the period of starvation. The observations on pyrexia were always made during the latter portion of this period, and to control the results the excretion of carbonic acid in the later period of simple fasting was observed also. The conclusion which the experiments suggest is that, without exception, the excretion of carbonic acid is greatly increased by the pyrexia. In those cases in which the elevation of temperature produced was most considerable, this increase in the carbonic acid amounted to nearly 80 per cent.; in four others to from 30 to 40 per cent.; and in two, with a moderate degree of fever, to from 10 to 20 per cent. The increase was always proportioned to the rise in temperature.

The experimenters suggest that the increased formation of carbonic acid cannot alone be held answerable for the rise in temperature. It represents one factor only, although one of great importance. A second factor is the altered discharge of heat under the influence of the cause of the pyrexia, the immediate mechanism of which is probably to be sought in a peculiar change in the innervation of the cutaneous and pulmonary vessels. Hitherto only one consequence of this altered vascular innervation was known—the rigour. Very recent experiments of Bachrach suggest another effect; it has been found that, under ordinary circumstances, substances, easily recognizable in the urine, as iodide of potassium, were absorbed far more quickly if injected under the skin than if administered by the mouth. In fever, however, the reverse is the case; iodide appears in the urine far more rapidly if given by the stomach than if injected under the skin.—*Lancet*, Nov. 30, 1878.

Increasing Paralysis among Women.—Dr. Jung (*Allegemeine Zeitschrift für Psychiatrie*, Band xxxv.) is of opinion that of late years paralysis, combined with mental disturbances, has been on the increase among women of the lower class. He explains this fact by the increasing misery and the decreasing power of resistance which predominate among the people. The disease generally manifests itself at the time of the cessation of the menses, especially between the thirty-fifth and forty-fifth years, which is later than in men. Paralytic women are either childless or they only have one child, or the children are stillborn or die at an early period. The paralysis generally follows close upon an attack of melancholy.—*Brit. Med. Journ.*, Dec 7, 1878.

Death from Chloroform.—Another case is recorded in the *British Medical Journal* for Nov. 9, 1878.

Homœopathy in the Calcutta University.—From the *British Medical Journal* we learn that the Senate of the University of Calcutta insisted on placing a homœopathic practitioner in the Faculty of Medicine, in consequence of which the other members of the Faculty sent in their resignation, as they declined to act in concert with the homœopathic professor. The result was that the objectionable member was removed from the Faculty, and the gentlemen who had handed in their resignation consented to resume office.

An Improved Microphone.—Surgeon-Major Wallich has for some months past been studying the mechanism of the microphone with a view to rendering it available for clinical purposes. Hitherto the microphone, when applied to the chest-wall, has conveyed to the ear of the listener an immensity of confused rumbling, proving effectually that the human body may be made to appear a very noisy machine, but without attaining the one object desired—viz., a clear differentiation of the sounds of the heart and lungs. Dr. Wallich has produced an instrument by means of which the heart-sounds are not only greatly increased in intensity, but remain quite distinct, the character of the two sounds being much intensified. By applying the microphone over the stomach we could hear the noise of water dropping into that organ from the œsophagus, and there is every reason to hope that Dr. Wallich's improved instrument may be made available for the purposes of clinical demonstration. Dr. Wallich intends shortly to test the value of his instrument in cases of heart and lung disease, when we shall return to the subject.—*Lancet*, November 30, 1878.

Personal.—The order of the Iron Crown of the third class has been conferred on Dr. Joseph Späth, Ordinary Professor of Obstetrics and Gynæcology in the University of Vienna, and President of the Sanitary Council of Lower Austria, in recognition of his valuable services in medical education and in sanitary work.

The following distinguished physicians and surgeons were recently elected honorary members of the Pathological Society of London: Drs. Gross, Charcot, Chauveau, Robin, Cohnheim, Thiersch, Pirogoff, Schwann, and Rindfleisch.

Mr. George W. Callender, F.R.S., Surgeon to St. Bartholomew's Hospital, is making a three months' tour in this country.

Mr. Andrew Clark, F.R.C.P. London, Physician in attendance upon the Marquis of Lorne and Princess Louise, in their recent voyage across the Atlantic, paid a flying visit to the States, and in New York on the 10th ult. delivered an interesting lecture at Bellevue Hospital Medical College, on the Varieties of Pulmonary Phthisis.

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VOL. XXXVII. FEBRUARY, 1879. No. 434.

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CLINICAL LECTURES.

ON IDIOPATHIC ANÆMIA.

A clinical lecture delivered at the Pennsylvania Hospital, Phila.

BY JAMES H. HUTCHINSON, M.D.
One of the Attending Physicians to the Hospital.

GENTLEMEN: Most of you are doubtless aware of the fact that there is a condition characterized by general anæmia, occurring without discoverable cause, in persons of both sexes, and in which no lesions are found which sufficiently explain its invariably fatal termination. It appears to have been recognized as long ago as 1823 by Andral, but it is to Addison, whose name is familiar to you all from its association with disease of the supra-renal capsules, that we owe the first distinct description of its symptoms. He describes its approach as insidious and unheralded by diarrhœa, hemorrhage, derangements of the menstrual function and purpura, or by splenic, renal, miasmatic, glandular, strumous, or malignant disease. The records of Guy's Hospital contain the reports of cases as they occurred from time to time, showing that the work of this distinguished physician had not been forgotten by its medical staff. Not so, however, in Germany, where certain observers have written of this disease as if it had been previously undescribed.

I happen to have in my ward a case which has been some time under observation, and in which anæmia is the most prominent symptom. This anæmia is, as you will see, extreme, but is not accompanied by marked emaciation. I can only explain it by referring the case to the class

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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to which I have just alluded. Without further prelude, I will read the notes of the case, which have been very carefully drawn up by Dr. Morris J. Lewis.

P. M., aged 50, a widower, was (first) admitted into the Pennsylvania Hospital on March 7, 1877. He was born in Ireland, but has lived most of his life in this country, working until very recently as a miner in the coal region of this State. So far as can be ascertained, he has no hereditary predisposition to disease. When a young man he enjoyed good health, interrupted, however, by an attack of jaundice and occasionally by attacks of acute illness, the nature of which he cannot tell, but for which he was occasionally bled. He admits having been rather immoderately addicted to the use of alcohol, and acknowledges that in early life he had an attack of gonorrhœa, but denies most positively ever having suffered from syphilis, and there is nothing in his history or appearance which makes his assertion at all improbable. About four years ago his wife died, causing him, he says, great grief and increased care. Since last fall he has been employed building a dam, but is sure that this was not the cause of his ill health. It appears upon questioning him that his fellow-labourers have since remained in good health, and that the region of country in which he was at work is free from malaria. He has never suffered from intermittent fever. He has had hæmorrhoids for fourteen years, but they never bleed except when he is constipated, and even then only a few drops. At no time has he had a large hemorrhage, sufficient to account for his pallor.

Until last December he considered himself perfectly well. At that time, however, he began to experience severe pain in the epigastric region immediately after the ingestion of food, especially if it were cold. Pressure in this region and also in that of the liver gave rise to a good deal of suffering. These symptoms were accompanied by anorexia and occasional nausea. Vomiting did not occur until just before his admission into the hospital, and then only on the cars during his journey to the city.

Slight cough has been present since the beginning of his indisposition, but the expectoration which attends it is scanty, and has never been blood stained. Besides the above symptoms, he has constantly been annoyed by roaring noises in his head, flashes of light before his eyes, and occasionally by vertigo, never so severe, however, as to cause him to fall.

Almost immediately after the beginning of his illness, his friends noticed that he was becoming very pale. This symptom has been increasing in intensity ever since. The hue of his skin, according to his statement, changes considerably from time to time, being occasionally quite yellow, and then again "putty-coloured." Notwithstanding his gradually increasing weakness he continued to work until about the 8th of January, when he was obliged to desist. At that time he noticed œdema of the ankles towards evening, and shortly afterwards he says his legs and thighs became œdematous, and pitted deeply upon pressure.

Upon admission, patient is exceedingly anæmic, his mucous membranes being almost totally devoid of colour. He is not jaundiced, but his skin is pale yellow in colour, probably of the hue which the French have described in similar cases as *teinte jaune sale.*

This discoloration is most marked in the face and upon the backs of his hands. It does not affect in these situations the scars which you see and which are the results of injuries produced by explosions in the mines. On the contrary, these are, by their whiteness, brought into marked contrast with the rest of the skin. He is slightly emaciated, but by no means as much so as we should expect in a case of such extreme anæmia. The percussion note is slightly impaired at the left apex both anteriorly and posteriorly, but no adventitious sounds can be heard. There is no dulness in the interscapular regions, and no signs of disease elsewhere in the chest. The liver reaches to the arch of the ribs, but does not extend beyond it. The spleen is not enlarged. Just below the arch of the ribs, and a little to the right of the median line, there is a spot exquisitely tender upon pressure. Pain is also produced by pressure upon the abdomen above the umbilicus, and in both flanks, but in these positions it is not severe. No enlarged glands or tumour of any kind can be discovered in the abdominal cavity, although they have been carefully looked for. There is slight enlargement of the glands of the groin. A loud systolic murmur is heard at the base of the heart to the left of the sternum, loudest in the recumbent position and distinctly transmitted to the apex. The "bruit de diable," which is heard in the right jugular vein, is also unusually loud and distinct. The patient is free from fever; his skin is soft and moist. He passes a normal amount of urine. Upon examination this is found to be high-coloured, to become cloudy upon standing, to be acid in reaction, and to have a specific gravity of 1010. It does not contain albumen or sugar.

He was placed upon the use of cod-liver oil fʒij, with twenty minims of the syrup of the iodide of iron three times a day, and also upon full diet with a bottle of porter at dinner.

At times a peculiar musty odour was observed to exhale from the patient's body, the cause of which could not be ascertained.

Before giving up the charge of the wards, which I did on May 1, a favourable change had taken place. The pallor and discoloration of the surface had diminished, the œdema had disappeared, and the tenderness over the epigastrium was scarcely any longer noticeable. The tongue and lips had gained colour, the venous hum in the neck and the cardiac murmur had both diminished in intensity; the former very much so. The treatment mentioned above was continued, the iron however being given in slightly increased quantity. It was perfectly well borne, vomiting only having occurred once during his stay in the hospital.

He remained in the ward until June 12, when he felt so well that he asked for his discharge. He was readmitted April 11, 1878. He tells us that after returning home he went to work again as usual, but was obliged to abandon it at the end of six weeks, since which time he has been at home idle. Upon his admission all his symptoms were found to have returned in their former intensity. The patient was as anæmic as before, while the emaciation was by no means marked. The same dusky hue of the skin, and the same peculiar odour, were observed. The venous hum and the murmur at the base of the heart were also distinctly heard. In fact, the patient's condition was then, as it is now, two weeks later, one of marked anæmia, and I am now, as I was then, unable to detect any organic disease which at all accounts for his present prostration. I have placed him again upon the same treatment which was apparently so successful before in restoring him to health.

There is one thing in the history of this case which may seem to you peculiar. I refer to the length of time the patient has survived the appearance of the first symptoms, and to the decided and long-continued remission which occurred. In most of the cases which have been reported recently, the disease pursued a much more rapid course, terminating in some cases in six weeks after the seizure, and rarely lasting more than six months. A sufficient number of cases have, however, been published, in which there was just as decided a remission of all the symptoms as in the case before you, to justify me in adhering to the diagnosis I made last spring. In a case reported by Dr. Habershon, in *The Lancet* for 1863, the patient, a woman, left Guy's Hospital in January, 1862, feeling herself to be entirely well; but was readmitted in the succeeding fall, presenting all her previous symptoms, in even greater intensity than before. A similar case is to be found among the cases reported by Dr. Samuel Wilks in the *Guy's Hospital Reports*, as long ago as 1857. And finally, just as marked a subsidence of the symptoms occurred in another case which was under my care, and to which I may allude more fully hereafter. I dwell upon this point because it does not seem to have been noticed by recent writers on this disease, with the exception of M. Lepine. It is one of some importance, however, because it is, in the first place, a reason for hesitating to accept the name, Progressive Pernicious Anæmia, given to the disease by Biermer, inasmuch as the disease is not always progressive, and for preferring that of Idiopathic or Essential Anæmia, proposed for it long before by Drs. Addison and Wilks; and because, in the second place, it adds strength to the opinion that the disease is allied to Addison's disease, and to the other forms of the so-called blood diseases.

Idiopathic Anæmia, as I prefer to call the disease, spares no age and neither sex. The patient before you is a man of 50 years of age. In the other case to which I have alluded as having been under my care, the patient was also a man, but only 25 years old. It occurs in old men of 68, and in young girls of 16, and is especially common in pregnant women, leading in them to abortion and premature delivery, as in the cases reported by Phillips and Gusserow. It selects its victims generally, but by no means invariably, from the lower ranks of life, so that authors have regarded poverty as among the predisposing causes. But whatever influence this may have in certain cases, because leading to insufficient nutrition, it cannot be invoked to explain the case before you, since the patient appears to have lived comfortably, having received during the greater part of his life wages as a miner, more than sufficient to support his family. In a case which I saw in consultation a few years ago, the patient was a well-to-do manufacturer. And in the cases reported by Gusserow the subjects were women, whose surroundings were quite as good as their neighbours'. Repeated pregnancy seems to be an exciting cause in women, but that this is not the only cause in such cases is shown by the fact that it has occurred in primiparæ. Mental anxiety has been also assigned as a cause, and it would seem not to be without its influence: thus the manufacturer just referred to is said to have been worried for some time by the condition of his business affairs. And among the reported cases is one in which the symptoms appeared shortly after the patient, a young girl, had accidentally poisoned her father. In the case before you grief for the death of his wife may possibly have played some part in the production of the disease. In another case which, after seeing at home, I got my friend, Dr. Kirkbride, to admit into this hospital, the patient's friends told me that he had never recovered from the loss of four daughters who had all died within a week of one another of smallpox. His grief is represented to have been excessive, leading him to visit their graves at night, and preventing him from taking any interest in his business.

As I have said, pregnancy appears to be a predisposing cause, and this undoubtedly is the reason that women are generally supposed to be more liable to this disease than men. If, however, we exclude cases occurring in pregnant women, we shall find that there is no great disproportion in numbers between the two sexes. Indeed, in 32 cases which I have examined with reference to this point, the patients were males in 20, and females in only 12 cases. In pregnancy, you will remember, there is a tendency to anæmia, and the tendency seems in certain cases to be very much increased. The disease, I have said, spares no age. It would appear, however, when it occurs independently of pregnancy, to affect preferably people in advanced life. Thus in the 32 cases above referred to, 18, or more than half the patients, were more than forty years of age, and of this number more were males than females. If we are willing to admit the existence of a congenital predisposition to this disease, we may explain the last-mentioned fact by assuming that the development of the disease in women is hastened by pregnancy, and that consequently they succumb to it by being exposed to an exciting cause before reaching the age of forty. I have not been able to find that the time of life has any influence upon the rapidity with which the disease runs its course when once set up. We would expect to find this disease more protracted in the old, but this does not appear to be the case. In the case of the young man of twenty-six, to which I have repeatedly referred, the disease had lasted considerably over a year at the time of his death.

The tenderness and fulness in the hepatic region, the slightly icteroid condition of the skin, and the tendency to nausea led me to suspect, upon the first admission of the patient, that he might be suffering from some form of disease of the liver; but I found, upon examination, no support for this view. The liver dulness was normal, and while the skin was universally of a dirty-yellow colour, there was no decided yellowness of the conjunctivæ. This remains true to the present day, and I am, therefore, able to exclude all diseases of the liver from consideration. Moreover, the dyspeptic symptoms which have been so prominent throughout this case are by no means unusual. I find it recorded in quite a number of cases that the patients suffered from nausea and vomiting, and from pain and tenderness in the epigastrium. In fact, digestive derangement is assigned as one of the exciting causes of the disease by M. Lepine.

In very many of the reported cases dropsy of the feet and legs has been quite as marked a symptom as in the case before you. In a few albumen has been found in the urine, but in such small quantities that it is inconceivable that disease of the kidneys could have been the cause either of the dropsy or of the extreme anæmia. The urine of my patient has been repeatedly examined, but always with negative results. In some cases pericardial and pleural effusions have been reported as present, but neither of these can be detected in my case.

I have called your attention to the peculiar hue of the patient's skin. He is not blanched, as he would be if he had only recently lost a large quantity of blood. Nor is the colour such as is ordinarily seen in jaundice, even of the mildest type. I have spoken of it as dirty-yellow, a term which is used by French writers in describing some of their cases. Indeed, the discoloration of the surface is so great that it suggested to the physician who attended him in the country, and who accompanied him to the city, the possibility that he might be suffering from Addison's disease. But it differs from that seen in the latter disease in several important particulars. It is universal, and not limited to the genitals and the exposed portions of the body. It is so much less intense, that it could never be mistaken for bronzing. There is, moreover, no staining of the buccal mucous membrane, which, on the contrary, is exceedingly pale.

The loud systolic murmur and the venous hum indicate the intensity of the anæmia, as do also the roaring noises in the ears and the vertigo. The cardiac murmur is heard best over the base of the heart to the left of the sternum, and is loudest when the patient is in the recumbent position. As there are no signs of hypertrophy or of dilatation, and no previous history of cardiac disease, it may be assumed to be a functional murmur, but there is no doubt that fatty degeneration of the heart, and especially of the columnæ carneæ, is present, and that this, by diminishing their contractility, causes an imperfect closure of the auriculo-ventricular valves, and hence permits of regurgitation through these orifices. In some cases, indeed, a decided thrill has been felt in the præcordial region, and then, of course, it may be difficult to decide positively against the existence of organic diseases. Murmurs may sometimes be heard in the arteries of the neck.

The blood upon examination was found to be thin and watery. Under the microscope there appeared to be an increase of the white corpuscles, but this was only relative, and was due to the great diminution in the number of the red. The result of this examination agrees with that obtained by the majority of other observers. A few have, however, made a more thorough investigation into the condition of the blood, both during life and after death. These have found it not only thin and pale in colour, being compared in one case to very weak coffee, but actually deficient in quantity, and incapable of coagulation. The red corpuscles have been found reduced to one-sixth, or even one-tenth of the normal quantity. According to MM. Ferrand and Hayem, the blood sometimes contains a larger number than in health of red corpuscles, the diameter of which is slightly exaggerated. These corpuscles are generally pale, but in the case reported by M. Ferrand possessed a greater colouring power than normal. This is believed to have been the consequence of the chalybeates which the patient had taken, and therefore no importance is to be attached to this observation. More often these large corpuscles are entirely absent, their places being taken by corpuscles which are not only smaller than normal, but are also defective in shape, apparently having lost their biconcave form. They also have no tendency to collect in rouleaux. They are so small that M. Lepine says they may readily be mistaken for globules of oil. M. Quincke has also called attention to what he calls "Corpuscules de desagrégation," which he believes result from the breaking up of the red corpuscles.

In my clinical lectures I have often spoken to you of the assistance which I have derived from the use of the ophthalmoscope in the diagnosis of obscure cases. In this case the result of an examination with this instrument was negative, and so it was in the only other case of the disease in which I had the opportunity to use it. In order to show you the importance of thoroughly examining the eyes, I will quote what Immermann says on this subject in his article on Progressive Pernicious Anæmia, in volume xvi. of Ziemssen's *Cyclopædia of Medicine:* "Of those internal hemorrhages that allow of being recognized during life, those into the retina are of peculiar interest, for they are, according to Biermer, among the most constant phenomena of the disease. They may be present in great numbers in both eyes; on ophthalmoscopic examination, which should never be omitted in doubtful cases, they appear either as small, black, reddish, or yellowish-brown spots, or as larger dark patches or clouds of irregular outline which veil a great part of the fundus, or lastly, as ecchymotic striæ radiating from the centre of the optic disk. When very minute, these extravasations may be present in great number without causing any disturbance of vision; on the other hand, solitary hemorrhages of larger dimensions give rise to sensible dimness of vision (and that very suddenly), to circumscribed obscuration of the visual field, etc." Just, as in Bright's disease, the patient sometimes seeks relief from the ophthalmic surgeon, in entire ignorance of the grave nature of the disease under which he is suffering.

In many cases the anæmia is very much increased by the frequent hemorrhages that occur in the course of the disease. These bleedings may take place from the gums, the nose, or rectum, and in women from the genital organs. They often unquestionably hasten the fatal issue, as they are occasionally very abundant and difficult to check. They depend, as do the petechiæ, which also sometimes occur, upon fatty degeneration of the vessels. Besides these visible extravasations of blood, others not unfrequently occur in internal parts, and may, when profuse, prove the immediate cause of death, as in one of Biermer's cases, in which death was the result of apoplexy. On the other hand, capillary extravasation may be found after death in the brain, in cases in which they had given no indication of their presence during life.

I come now to the consideration of a symptom of some interest, which however has not been present—certainly not in a marked degree—in the case before you. I allude to the fever which generally occurs towards the close of life in this disease. It has never been observed to precede the anæmia, and often terminates abruptly as death approaches, when the high temperature gives place to a subnormal one. Its explanation is not easy. It would seem unlikely, as Immermann says, that any active febrile process can be long sustained when the oxygen carriers are so much diminished in number as they are in this disease, and yet the temperature of the body has often been observed to rise as high as 104°. You are doubtless aware that a similar fever occurs in the course of leucocythæmia. M. Lepine thinks that it is not impossible that this fever is set up by the products of a retrograde metamorphosis, which are present in larger than normal quantities in the blood, as shown by the large amount of nitrogen passed in the urine. Unfortunately for this theory, as he himself points out, the fever subsides just before death, although the excretion of nitrogen has not diminished.

I shall allude very briefly to the results of post-mortem examinations in these cases. As I have, unfortunately, never had the opportunity of witnessing one myself, I shall have to borrow my descriptions from others. The occurrence of extravasations of blood in many parts of the body, and of fatty degeneration of the heart and bloodvessels, has already been mentioned. The latter is sometimes extreme, and is generally accompanied by a similar degeneration of the liver and kidneys. Indeed this alteration is so marked that it led Dr. Wilks to give the name of "Idiopathic Fatty Degeneration" to the disease. It is unquestionably due to the deficient nutritive properties of the blood, and may be brought about in animals by subjecting them to copious bleedings. Ponfick found in one case fatty degeneration also of the cells lining the gastric follicles, and in one of the cases, reported by Dr. Pepper, there was chronic follicular catarrh of the intestines. There is no disease of the spleen, lymphatic glands, or medulla of the bones, which of course makes this disease a distinct one from pseudo-leucocythæmia. In one of Dr. Pepper's cases there is said to have been extreme hyperplasia of the marrow with production of lymphoid cells, which leads him to conclude that idiopathic anæmia is the medullary form of pseudo-leucocythæmia. On the other hand, Lepine, in commenting on this case, says that the changes in the medulla of the bones were insufficient to justify him in drawing the conclusion he does; and Immermann assigns the fact that there were these changes in the marrow of the bones, as a reason for not referring one of his cases to the former disease.

My lecture is already so long that I will not take up much of your time in speaking of the diagnosis of the disease. It can scarcely, after due study of the various symptoms, be confounded with anything else. At first, just as in the case before you, there may appear to be an organic disease of some organ; or, on the other hand, a cancerous tumour—of the stomach, for instance—may elude our search, so as to lead us to believe that the attendant anæmia is idiopathic, and not symptomatic. But time in both these cases will generally enable us to arrive at a correct conclusion. Indeed in cancer there is almost always marked emaciation, which, as I have told you, is generally absent in this disease. From chlorosis there is usually no difficulty in distinguishing idiopathic anæmia, since the former rarely remains unrelieved by treatment. The absence of splenic and glandular enlargement, and of disease of the medulla of the bones, would prevent us from mistaking a case of this disease for one of any of the forms of leucocythæmia or pseudo-leucocythæmia, and the absence of bronzing will render it improbable that the case is one of Addison's disease.

The prognosis is, as I have already told you, unfavourable. I doubt whether there is a single well-authenticated case of recovery. There may, however, be, just as there are in Addison's disease, marked remissions which may mislead the physician into believing that he has effected a cure, or that he has made a mistake in diagnosis. That treatment is not entirely unavailing may be inferred from the fact that these remissions do occur, and it is possible, when we become better acquainted with the pathology of the disease, that we may sometimes be able to arrest it.

In the two cases which I have treated in this hospital, I gave cod-liver oil and iron, and the improvement in the symptoms, which resulted from their use at first, would certainly seem to prove that they were appropriate remedies. Broadbent has proposed to give phosphorus, but it has not been found to be of benefit in the cases in which it has been employed. Various other remedies have been recommended, but in the majority of cases have failed to effect any good results. In those cases occurring during pregnancy, there would seem to be no possible objection to carrying out Gusserow's suggestion to bring on a premature delivery, as this usually occurs if the patient is left to herself. If it is done before the anæmia has reached an advanced degree, it may possibly be successful in cutting the disease short. Transfusion has been performed in several cases, but it has never produced anything more than a temporary improvement, and in some instances seems to have accelerated the fatal issue. Indeed, whether the disease depends upon an increased consumption or diminished production of the blood, a point not yet settled, it is not easy to see how the injection of blood into the vessels would exert anything more than a passing influence. As it is an operation not wholly unattended with danger, it is not to be indiscriminately performed.

HOSPITAL NOTES AND GLEANINGS.

Case of Aortic Aneurism treated by Galvano-Puncture.—Charles J., aged forty-four, labourer, married, a short, well-made and muscular man, formerly a soldier in the infantry, was admitted Aug. 13th, 1877, into the West Bromwich Hospital, under the care of Mr. H. L. Browne. He had served for ten years, chiefly in the East Indies. He left the army in 1865. Afterwards he was employed as a labourer in loading carts and lifting heavy weights of coal, and was frequently in cold and wet. His health had always been good: no history of syphilis. Father of eleven children, all healthy. During the previous March he perceived swelling in the right breast. There was no pain until the beginning of July, when he began to feel sharp pains, with shortness of breath. The swelling then rapidly increased, but he continued to work up to the time of admission, and his face was blue and congested. There was great difficulty in breathing, the voice was hoarse, and the superficial veins were very much enlarged, especially over the chest and abdomen. The heart-sounds were feeble. Pulse 98, and apparently smaller and retarded at the right radial as compared with the left. The tumour extended in an oblique direction from the right side of the sternum opposite the second costal cartilage down to the fifth rib. Dull on percussion, it fluctuated markedly, and pulsated visibly, with a heaving, distinct, and expansile movement. There was no aneurismal bruit, but systolic and diastolic sounds were heard over the tumour similar to heart-aortic sounds. The heart's apex was normal. The apex of tumour at the third right intercostal space was about the size of a hen's egg, and protruded in consequence of absorption of the right edge of sternum. The symptoms pointed to sacculated aneurism of the convex side of the ascending aorta. The lung-sounds were normal (the dyspnœa and the hoarse voice were evidently caused by pressure on the recurrent laryngeal and the pulmonary branches of vagus).

On Sept. 12th two gold-plated needles were introduced between the third and fourth and fourth and fifth ribs, and connected alternately with the positive and the negative poles of a Stöhrer's battery, two, four, and six cells being used for twenty minutes each. There was no cauterizing, nor was there hemorrhage on withdrawal of needles. Ice-bags were applied for two days to ease pain. The tumours became flatter; fluctuation disappeared; the pulsation was less, and the walls of the sac were decidedly thicker.

On October 9th galvano-puncture was again applied. Two plated needles placed between third and fourth ribs were connected with the positive current from four cells, and a damp electrode applied over the sternum. No hemorrhage or cauterizing. There was but little pain. Still more marked improvement followed; the prominent apex of the tumour flattened down, and the general health was very good. The pulsation was evidently deeper and less, and thickening of sac-walls was greatly increased.

On Nov. 16th two large insulated needles with steel points introduced between the third and fourth ribs, about one inch and a half apart, were seen to diverge strongly at each pulsation of the aneurism. Connection was made with the positive current from eight cells of Stöhrer's battery, and a sponge in a hollow copper handle connected with the negative and applied over the sternum; in forty minutes the needles were quite still. The current was kept up for thirty minutes longer. All pulsation in the sac ceased. No hemorrhage followed, and the pain was slight.

On Nov. 20th the tumour felt solid. No pulsation, the swelling only moving with the movements of the artery.

Dec. 2d.—No pulsation. General health so good that the man thought he was cured, and bolted from the hospital at night. Was not again heard of until Feb. 1878, when he was in the Queen's Hospital, Birmingham, as bad as when admitted to the West Bromwich Hospital.

This case shows the difference in galvano-puncture between the action of plated and insulated needles. In the former the current is probably most expended on the walls of the sac, and it is there deposition of clot takes place, and therefore this treatment might be available for dilatation of the aorta as well. In the latter the sac contents are coagulated, and it would seem that where sacculated aneurism can be clearly made out (much the more frequent form in the aorta) the current might with safety be kept up sufficiently long at one sitting to stop all pulsation. If the sponge is applied over the sternum, where there is only skin covering, there is very little pain. Over the pectoral and the intercostal muscles sharp twitching and pain are produced at once. It also shows how very long a clot produced by galvano-puncture takes to become organized, and how the most absolute rest (even using the arms to feed with is unsafe) is requisite for many weeks to produce a successful result.—*Lancet*, Oct. 26, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Rapid Lithotrity.—At a late meeting of the New York Pathological Society (*Med. Record*, Jan. 25, 1879), Dr. SANDS presented a vesical calculus which he had removed by Bigelow's operation of rapid lithotrity. The patient was a gentleman sixty-nine years of age, of delicate constitution, and who had suffered for a long time from lung trouble supposed to be chronic phthisis, and who had at the time he came under observation slight albuminuria, the urine also containing hyaline casts. Symptoms of stone showed themselves two years before the operation, and during the summer of this year he was examined by a gentleman of this city, who referred him to Dr. Sands. Dr. S. saw the patient in consultation with Dr. DeHart, at Chappaqua, and performed the operation on the 28th of October last. The urine contained a moderate amount of pus and triple phosphate. Although it had been noticed at previous examinations that uric acid was contained in the urine, it was believed that the stone was hard. So it proved to be. The operation lasted one hour and ten minutes. The fenestrated lithotrite was used. The aspirator was employed twice only. The first time the fragments were removed, the second time the bladder was thoroughly emptied. The prostate was enlarged. The urethra was capacious and would have admitted a larger tube than the one employed. The size used was No. 28, and was a curved one, the straight tube having failed to enter. The stone was found to consist of uric acid. It measured in diameter one and a quarter inches. It was pretty thoroughly crushed before the aspirator was used. When the tube was inserted the first gush of urine carried with it a considerable quantity of detritus, which was not collected. The fragments which were obtained weighed ninety grains. The patient had no bad symptoms after the operation. In the third week he was able to get out of the house, and within a month walked two miles and a half without discomfort.

In conclusion, Dr. Sands remarked that Bigelow's method was a decided improvement upon the old one, and that the apparatus devised by Dr. B. embodied so many important improvements of Clover's apparatus that it was virtually a new departure.

Last autumn Dr. Bigelow presented and explained his new method which he originally described in the *American Journal of the Medical Sciences* for January, 1878. His method is favourably spoken of by the English journals and one of them, the *Lancet* (Nov. 2, 1878), says "we cannot but think that this development of lithotrity will introduce a new era in the treatment of stone, and we await with considerable interest the results of its adoption by English surgeons."

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To Avoid Scars after Incisions.—Dr. John H. Packard, of Philadelphia, recommends (*Phila. Med. Times*, Dec. 21, 1878) that in making superficial incisions the skin should be divided obliquely, as in this way he claims scarring can be avoided. This method was suggested to him by witnessing the effects of an accident, a lady having fallen while carrying a china dish, a piece of which made a long, gaping, incised wound in her hand, the sharp knife-like edge of a fragment having cut through the skin very obliquely. After approximation the wound healed readily, almost without a scar. The traces of the injury could scarcely be discovered a few weeks afterwards.

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Statistics of the Medical Journals of the United States.—Dr. J. S. Billings, U. S. A., publishes in the *Boston Medical and Surgical Journal*, Jan. 2, 1879, on the occasion of the completion of its fiftieth year, some interesting and instructive statistics of the medical journals of this country, from which we gather the following:

From the years 1797 to 1878, 250 journals have been begun, of which 196 have terminated their career. Of these 10 issued only a single number, 21 did not complete their first volume, 61 (about one-fourth of the whole number) did not go beyond the first volume, and 39 not beyond the second volume.

At the time of the commencement of the *Boston Medical and Surgical Journal* (Feb. 19, 1828) eight medical journals were in existence in the United States, namely: in Philadelphia, The American Journal of the Medical Sciences, The American Medical Recorder, The Monthly Journal of Foreign Medicine, The North American Medical and Surgical Journal, and The Philadelphia Monthly Journal of Medicine and Surgery; in New York, The New York Medical and Physical Journal; in Cincinnati, The Western Medical and Physical Journal; and in Lexington, Ky., The Transylvania Journal of Medicine. Of these the *American Journal of the Medical Sciences*, now in its fifty-ninth year, alone survives.

Of the medical journals which were in existence at the birth of the *American Journal* only the following are still published:

Annali Universali di Medicina. Milano, 1817.

Gazette de Santé, continued as the Gazette de Médecine de Paris. Paris, 1773.

The Edinburgh Medical and Surgical Journal, continued as the Edinburgh Medical Journal. Edinburgh, 1805.

Recueil Périodique de la Societé de Santé de Paris, continued as the Revue Médicale Française et Etrangère, Paris, 1797.

Journal de Médecine, de Chirurgie, et de Pharmacie Militaires. Paris, 1815.

Reil's Archiv für die Physiologie, continued as Archiv für Anatomie and Physiologie. Halle, 1796.

The Boston Medical and Surgical Journal on the completion of its fiftieth year, exhibits undiminished vigour and energy, and under its present able editorial management it very creditably fills the sphere of a weekly medical journal.

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Public Health Legislation.—There exists a wide-spread and well-founded fear of hasty and inconsiderate national legislation on sanitary matters, prompted by the recent epidemic of yellow fever. Congress has appointed a select committee to investigate and report the best means of preventing the introduction and spread of epidemic diseases, and the Senate has referred to this committee a bill introduced by Mr. Lamar, of Mississippi, "To establish a Department of Public Health." The bill provides for the abolition of the Marine Hospital service, and the creation of a Department of Health, under the charge of a Director-General of Health, at a salary of $7500 per annum.

The duties of the Director-General of Health are "to make and enforce all quarantine and other regulations for the prevention of cholera, yellow fever, and other epidemic diseases in the United States"; to select quarantine stations and erect such necessary temporary buildings and "enforce such transhipment of passengers, baggage, and cargoes as he may deem necessary"; to prepare suitable tables for the taking of each census; to procure information relating to the climate, meteorological, geological, and other conditions affecting the public health; to employ persons of proper scientific knowledge and skill to make special investigations on subjects connected with the public health, at such compensation as he deems reasonable and just.

Such in brief are the extraordinary, we are almost tempted to say dictatorial, powers which this bill proposes to confer upon an appointee that is to know no superior save the President, who may for cause suspend him from the discharge of official duties; but cannot remove him from office except upon hearing before the Chief Justice of the United States.

Unfortunately, the committee to which this bill has been referred has, in advance, given ground for distrust of the results of its deliberations, by its course in the appointment of sanitary "experts" to assist it in its investigation of the late yellow fever epidemic. Of the thirteen experts selected twelve are "doctors." Of these but two are known as sanitarians, one is a homœopath, and the larger proportion are not known at all to the profession. Of course but little can be hoped for from a committee in which influences prevail that can produce such results.

In the opinion of the American Public Health Association, as expressed in a memorial just issued, and endorsed by the leading sanitarians of the country, and we believe it correctly represents the views of the profession at large, "the true interests of Public Health and of Sanitary Science in the United States are in great danger at the present time, and it is the duty of all professional and scientific men, both as individuals and as members of learned societies, to endeavour to prevent premature legislation which is now threatened."

The Public Health Association advocates the appointment of a Provisional National Health Commission, the objects and duties of which should be: *a.* To report to Congress at its next session a plan for a permanent National Public Health Organization, said plan to be prepared after consultation with State Boards of Health, and with all those who possess special knowledge or experience bearing on this subject. This plan should include one for a National System of Quarantine. *b.* That it shall take charge of any investigations into the causes and means of prevention of yellow fever or other epidemic diseases which may be referred to it by Congress, selecting experts for that purpose so far as may be necessary.

According to this plan this commission should be composed of men well known for their scientific attainments and knowledge of Public Hygiene. And in order that it may be unbiased by political or local considerations the Association suggests that Congress should request the National Academy of Sciences to designate the members.

The scheme proposed by the Public Health Association commends itself by the care and deliberation with which it proposes to rear a plan for a National Health Board.

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Information on Climatology. — Dr. WILLIAM PEPPER, of Philadelphia, has been for some time past engaged in the preparation of a practical work on the climate of America. At the last meeting of the American Medical Association a committee was appointed to report on the health resorts and mineral springs of America, and it has been decided that the materials collected by Dr. Pepper shall serve as the basis of this report. A circular has accordingly been prepared by Dr. Pepper for distribution, accompanied by an endorsement and appeal from Dr. H. I. Bowditch of Boston, the chairman of the committee.

The questions to which replies are earnestly requested are as follows:

1. What are the recognized, and, in your judgment, deserving places of resort in your State?

2. What special forms of disease are benefited by residence in those localities? Are there any places in your State peculiarly beneficial to consumptive patients?

3. What are the peculiarities of these localities in regard to altitudes, soil, wind, temperature, rain-fall, humidity of air, etc.?

4. What are the prevalent diseases of these districts at different seasons, and what precautions are necessary for visitors to observe?

5. What are the accommodations for visitors, cost of living, inducements for exercise, and opportunities for sport?

6. What mineral springs or baths of established value exist in your State? What is their chemical nature?

7. Can you forward any publications on these subjects, or give any references to reports on analyses?

If throughout the country, each one will help, even to a small extent, a great fund of valuable and reliable information may be secured. The answers may be written on separate slips of paper, marked with the number of the question. It is highly important that the replies should be received as promptly as possible. All communications should be addressed to Dr. William Pepper, 1811 Spruce St., Philadelphia.

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OBITUARY RECORD.—At Boston, on the —— of January, aged 73, JOHN B. S. JACKSON, M.D., Professor of Pathological Anatomy in Harvard University.

Dr. Jackson was born in Boston in 1806, graduated in the arts at Harvard University in 1825, and in medicine four years later. He early turned his attention to morbid anatomy, and prosecuted its study earnestly and with enthusiasm. To his labours chiefly the Boston Society for Medical Improvement owes its valuable cabinet of which, in 1847, he published a Descriptive Catalogue of 350 pages. He was also curator of the Warren Museum, and in 1870 published its Descriptive Catalogue of 750 pages. These two volumes are more than a mere catalogue, they contain much valuable information, and very substantial contributions to gross pathology.

——At Boston, on the 10th of January, aged 91, JACOB BIGELOW, M.D., formerly Professor of Materia Medica and Chemistry in Harvard University.

Dr. Bigelow was born in 1789, and graduated at Harvard in 1806. In 1814 he published his *Florula Bostoniensis*, which is still an authority on the subject, and five years later his beautiful plates of American Medical Botany. He was a contributor to the *American Journal of the Medical Sciences*, and the author of a number of essays, the most important of which were collected together in 1867 and published in a volume entitled *Modern Inquiries*. He was a gentleman of many virtues, great abilities and scholarly attainments, courteous, dignified, and universally esteemed and beloved. He was for many years president of the American Academy of Arts and Sciences, and at one time president of the Massachusetts Medical Society.

——At Philadelphia, on the 19th of January, aged 63, JOHN B. BIDDLE, M.D., Professor of Materia Medica and Therapeutics in Jefferson Medical College.

Dr. Biddle was born in Philadelphia in 1816, graduated in medicine at the University of Pennsylvania in 1836, and subsequently studied abroad. In 1838, in conjunction with Dr. Meredith Clymer, he started the *Medical Examiner*, and remained in the editorial management for five years. In 1865 he was elected professor in the Jefferson College. At a special meeting of the Faculty, held on the 20th ult., the following minute was ordered to be entered upon the record:—

"The Faculty of Jefferson Medical College find themselves plunged into the deepest sorrow by the death of their fellow-member, Dr. John B. Biddle, Professor of Therapeutics and Materia Medica and Dean of their body, which occurred on the evening of the 19th inst. As a friend, they feel sadly the void thus created, and mourn over the departure of a greatly loved companion. Endeared to them by his noble qualities of head and heart, as their colleague and executive officer, they realize the irreparable loss of a sound and sagacious thinker, an able and successful teacher, and a faithful, experienced, and judicious executive, whose untiring zeal and earnest labours in his own department, and for the school at large, have contributed so much to maintain the usefulness and advance the reputation of Jefferson Medical College.

"The Faculty feel that words are inadequate to express their sense of this bereavement, but desire to make record of the estimate in which they held the deceased, whose memory they will ever cherish with sincerest affection.

"They desire to convey to his sorrow-stricken family their warmest sympathy, trusting that in the knowledge they have of the esteem in which he was held in the community, and the love which was borne him by all his co-labourers and friends, and that he has left them in the assurance of a Christain faith for that larger life which is eternal, they find comfort and consolation.

"*Resolved,* That a copy of this testimonial of the Faculty be transmitted to the family of Dr. Biddle, and also to the honourable Board of Trustees; and that the Faculty will attend his funeral in a body."

FOREIGN INTELLIGENCE.

Hysteria with Complete Anuria.—Dr. VINET has published a very curious case of complete anuria in the *Nice Médical.* The patient, a lady aged 38, had always been of a nervous temperament; but for some time past she had been subject to very singular paroxysms, which occurred regularly in the course of four or five days. Both digestion and circulation seemed much affected; the patient, however, did not grow any thinner, but only weaker from day to day; the slightest movement would cause such severe palpitation of the heart, that she could no longer stand upright. The only food which the patient was able to take was a small cup of coffee and milk; everything else was immediately rejected. Her weakness at last increased so much, that she was obliged to spend her days reclining on a chair, not being able to move. This wretched state lasted for two years and a half, then grew worse, while the hysteriform paroxysms were repeated more often than before; while they lasted, the patient was totally unconscious, and all her extremities more or less contracted. From this movement, the vomitings increased, and she could not take any food at all without throwing it up. But the most remarkable phenomenon during the latter time of the disease was, that both micturition and defecation were entirely suspended from December 24, 1877, to February 22d of the following year. During this period of fifty-eight days, the paroxysms were more frequent than ever before; several attempts were made to draw the urine by means of the catheter, but the bladder was always found to be empty. A short interval of normal evacuations then took place, when the same state as before again set in, and lasted till May 4th.—*British Med. Journal,* Dec. 21, 1878.

Warts Treated by Chromic Acid.—According to the *Révue Médicale* (Dec. 2), three or four applications of chromic acid suffice to cause the disappearance of warts, however hard and thick, and of whatever size. The application causes neither pain, suppuration, nor cicatrices, the only inconvenience being that the warts become of a blackish-brown colour.—*Med. Times and Gaz.,* Dec. 14, 1878.

The Organization of Thrombus.—The results of a series of investigations undertaken upon a large number of animals have recently been published by P. BAUMGARTEN. His method of proceeding, as given in the *Centralblatt fur Chirurgie,* was to isolate a considerable portion of the vessel, and to surround it completely with blunt hooks. Two threads were then passed round the vessel at a distance of about an inch, the peripheric one being first tied in the case of the artery, the central in the case of the vein. To the wall of the part included between the ligatures a little cinnabar suspended in a 2 per cent. solution of carbolic acid was applied. The cutaneous wound was sutured with carbolized silk. The animals were killed at various intervals after the operation, aud careful macroscopic and microscopic observations made. The conclusions at which he arrived were:—The so-called organization of a thrombus consequent on ligature is due to two essentially different processes. First, to a growth of the endothelium of the vessel; and, secondly, to an inflammatory outgrowth of the vascular wall and of the adjoining tissue, which penetrates into the cavity of the vessel from the point of ligature and from lateral fissures, and ultimately through and from the uninjured wall of the vessel itself. It is to the development of bloodvessels in this last material alone that Baumgarten attributes the organization or vascularization of the thrombus.—*Lancet*, Dec. 14, 1878.

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An Improved Method of Staining Microscopical Specimens.—Dr. G. Broesicke, keeper and assistant at the Berlin Pathological Institute, recommends (*Centralblatt Med. Wiss.*, No. 46, 1878) a combination of osmic acid and oxalic acid for staining the tissues instead of osmic acid alone. Small pieces of the tissue, or prepared sections, are placed for an hour in 1 per cent. osmic acid solution, and then carefully washed to remove all superfluous acid. They are then immersed for twenty-four hours or longer in a cold saturated aqueous solution of oxalic acid (one to fifteen), and are ready for examination in water or glycerine. The result is that while certain substances—such as mucin, cellulose, starch, bacteria, the outer coat of certain fungi, the axis-cylinder and white substance of Schwann, etc., are scarcely at all coloured, other tissues, such as the vitreous humour, the substratum of the cornea, the walls of the capillaries, and various intercellular connective tissues, appear of a bright carmine, and muscular fibres, tendon, hyaline cartilage, the inter-fibrillary substance of decalcified bone, and most of the tissues rich in albumen, are stained a darker carmine. The gray substance of the central nervous system, most nuclei, and many cells, assume a dark Burgundy red tint. In all these cases, however, each particular tissue is stained a slightly different shade, so that it can be readily differentiated from its neighbours. None of the objects treated by this method swell up or exhibit signs of internal coagulation. The oxalic acid produces darker or lighter shades in proportion to the length of time the specimen had previously been immersed in osmic acid, and if the latter has once completely blackened the tissue the oxalic acid is powerless afterwards to redden it. Mixed solutions of osmic and oxalic acids stain proportionately to the relative strength of each. The chief drawback to this method is the small penetrating power of osmic acid, which prevents the whole thickness of a specimen from being equally stained.—*Med. Times and Gaz.*, Dec. 14, 1878

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Prize Essay on Hydrophobia.—The prize of £100 offered by Mr. Stanford, M.P., for a prize essay on hydrophobia, is to be opened for competition to foreigners as well as to Englishmen, and the Marquis of Salisbury has instructed the British Minister at Washington to bring the subject to the attention of the Department of State. The essay must be delivered to the Royal College of Physicians of London, who are to adjudicate, on or before January 1, 1880.—*Med. Times and Gaz.*, Dec. 14, 1878.

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Prof. Brown-Séquard at the College de France.—According to the *Progrès Médical* (Dec. 7), the following somewhat remarkable programme is set forth by the successor of Claude Bernard in the first of the lectures which he has just commenced at the College de France.

"He will investigate the action of the brain on the spinal cord, discuss the question of the existence of two brains or of a single one, and pass in review all the lesions of the brain which can give rise to physiological and pathological phenomena. In his opinion, each half of the brain possesses all the functions of the encephalon, being capable of every action and able to appreciate every sensation. He hopes to demonstrate that the necessity for a *decussation* of the nervous fibres of the right side with those of the left, and the reverse, is not indispensable; and that each half of the brain can appreciate the sensitive and sensorial impressions of the two sides of the body.

"Relying on the fact that the fibres of communication between the encephalon and the cord are only few in number, the Professor declares that, in his opinion, the theory of a nervous key-board (*clavier nerveux*) is false and should be rejected. The mechanism which he hopes to obtain acceptance for implies the hypothesis of the existence of psychical powers diffused in the cerebro-spinal axis transmitting its sensations to the nervous cells. And the mode of communication between these various psychical powers and the intellectual power takes place by means of a kind of galvanic current. Very few communicating fibres are therefore sufficient for the transmission of the message to the nervous cells ready to receive it.

"'I believe,' M. Brown-Séquard observed, 'in the existence of cerebral localizations; but I maintain that these localizations, in place of consisting in a limited point of the brain, exist in another manner. They consist of elements everywhere disseminated, so that each centre possesses cells of very varied functions.' As is evident, the Professor seeks for the admission of doctrines into physiology radically opposed to those which are received at the present time, of which he makes a *tabula rasa*. He has already expounded his theories before the Société de Biologie, and since then abroad, and especially in the United States.

"We may add that, in commencing his lectures, Prof. Brown-Séquard expressed his intention not to engage in experimentation like his predecessor, Claude Bernard, but especially to rely on facts for the demonstration of his doctrines. 'Experiments in this matter,' he observed, 'are very difficult, for they are under the dependency of *irritation*, and they often fail. It is my confidence in the truth, and the number of facts which I have collected, that will sustain me in the course I have traced out for myself.'"—*Med. Times and Gaz.*, Dec. 14, 1878.

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Female Pharmacists in Holland — In 1865, a young lady, Miss Tobbe, applied to the Medical Commission of Holland for permission to obtain her title of pharmaceutical student, for the purpose she wished of making herself useful in her father's apothecary shop. The Commission replied that the request was so extraordinary that it could not take upon itself the responsibility of replying, and advised the petitioner to apply to the Minister of the Interior. This was done, and the result was a direct refusal. In Article 17 of the instructions for the apothecaries, the pronoun "he" was used; and hence, it was argued, male pupils alone were meant. The law of 1866, concerning the provinces of the healing art, admits women as well as men to be examined as pharmaceutical students, pharmaceutical assistants, and as chemists. In 1868 Miss Tobbe obtained her title of pharmaceutical student. She has had many imitators. Since the new law came into force a hundred ladies have been received as pharmaceutical students. The examination of a pharmaceutical student includes the Dutch language, arithmetic, Latin, reading, and explanation of written prescriptions, as well as some of the prescriptions of the *Dutch Pharmacopœia;* a theoretic knowledge of physics; a common knowledge of remedies by their exterior characteristics; the origin of medicines; their scientific names with their synonyms; and the preparation of prescriptions. The future female druggists, of whom the larger number are the daughters of country medical men or druggists, are not only placed in their fathers' dispensaries, but are sought after by the druggists of the large towns, especially in Amsterdam, and even for the "Bureau de bienfaisance." They are recommended by their orderly habits and their cleanliness and accuracy.—*London Med. Record*, Dec. 15, 1878.

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Obituary Record.—At Paris, on the 14th of December, 1878, aged 72 years, Pierre-Antoine-Ernest Bazin, Physician to the Hôpital Saint-Louis.

Dr. Bazin may be looked upon as the founder of the present school of dermatology, which is so ably represented at the Saint-Louis, where his clinical teachings annually attracted large numbers of students.

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CLINICAL LECTURES.

THE OPHTHALMOSCOPE IN DISEASES OF THE NERVOUS SYSTEM.

A clinical lecture delivered at the Hospital of the University of Pennsylvania, Jan. 23, 1879.

By WILLIAM F. NORRIS, M.D.
Clinical Professor of Ophthalmology in the University of Pennsylvania.

GENTLEMEN: You will remember that in my two previous lectures, I have described and pictured to you, by means of coloured images projected on the screen, the normal eye-ground, its physiological variations, and the changes produced in it by hemorrhages, embolism, Bright's disease, leucæmia, and syphilis; and today I propose to illustrate and describe to you some of the more common intraocular changes accompanying certain well-marked lesions of the nervous system.

That the eye should be one of the most sensitive indicators of disease in the central nervous system, seems only natural when we consider its close anatomical relations with it, and its rich supply of cranial nerves. The optic nerve and retina are, from a genetic point of view, part of the brain, being, as it were, sprouts from the anterior cerebral vesicle, and besides this, its nerve of special sense, five other cranial nerves are distributed to the eye and its appendages (viz , 3d, 4th, 5th, 6th, and 7th pairs); and three of these (3d, 4th, and 6th) are distributed exclusively to them. Consequently, lesions of these nerves in any part of their course, or at their points of origin in the brain, constantly cause impaired function of the parts to which they are distributed; *e. g.*, palsy, either com-

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plete or partial, of the iris, or of the ciliary muscle, producing irregularities in the pupils and blurred sight—of the external muscles of the eye, causing double vision, inability to open or close the lids—of the fifth nerve giving rise to anæsthesia of the cornea, etc. Moreover, experience shows that many cases of impaired nutrition, inflammation, and atrophy of the optic nerves, are dependent on lesions of the central nervous system. We will pass by for the present those cases where intra-cranial disease does not reveal itself by any visible change in the eye-ground, but which, by affecting the optic tracts, corpora quadrigemina, or cortical centres, produce marked defects in the field of vision (Hemianopsia, Symmetrical Scotomata, Peripheral Limitations), and confine our attention to a few of those cerebral lesions which produce marked changes in the eye-ground.

Double Optic Neuritis.—Many systematic writers have endeavoured to draw a sharp line of demarcation between those forms of neuritis, accompanied by great swelling of the intra-ocular end of the nerve, where the tortuous, dilated veins are seen alternately veiled by, and emerging from the swollen and partly opaque nerve-fibres, as they run down from the bulging disk (now forming a true papilla) to regain the level of the retina; and those forms of neuritis where there is but little swelling of the disks, and the changes on them are limited to increased capillary congestion, and such clouding of the retinal fibres as either obscure or hide its outlines; but although this classification is convenient for description, we constantly find the one condition shading off into the other, and although in typical cases the distinction is easily apparent, it is by no means always possible to distinguish the appearances of the so-called choked disk where the changes are limited to the intra-ocular end of the nerve, from those caused by a descending neuritis—the one form passing at times so gradually into the other, that it is impossible to point out exactly the line of demarcation between them.

Double optic neuritis may be produced by any cause which gives rise to a considerable and long continued increase in the intra-cranial pressure. Thus Aneurism, Hydrocephalus, or Tumour, etc., may all give rise to it, but clinical experience shows that the causes most frequently producing it are intra-cranial tumours and basilar meningitis. In cases of simple choking of the disk, dissection shows that the pathological changes are, for the most part, limited to the intra-ocular end of the nerve, and the absence of a continuous anatomical chain of abnormal tissue between the focus of disease in the brain and the point of most marked change in the optic nerve, has naturally led physicians to cast about for an explanation of it. Graefe, who was the first, since the introduction of the ophthalmoscope, to insist on the frequency with which double neuritis accompanied brain tumour, supposed that it was caused by the back water movement of the venous blood, produced by the increased pressure on the sinuses of the dura mater, and thence transmitted by the ophthalmic to the central retinal veins; the Lamina Cribrosa acting as a multiplier, and increasing by its constriction of the vessels, the œdema, and congestion of the intra-ocular end of the nerve. The anatomical investigations of Seeseman have since shown that the anastamoses between the ophthalmic, orbital, and facial veins, are so free, that it is not at all probable that intra-cranial pressure can thus be transmitted through the veins to the eye-ground.

Benedict has attempted to explain the state of affairs by supposing that a local palsy of the sympathetic is the cause of choked disk; but it is scarcely possible that this palsy should always be limited to the few filaments supplying the intra-ocular end of the nerve, and symptoms of paresis of other branches, such as contraction of the pupil, partial ptosis and flushing of the face, are notoriously absent in such cases. Since Schwalbe and other anatomists have demonstrated the free connection of the lymph space between the pial and dural sheaths of the optic nerve, and the corresponding lymph space in the cranium, the attention of observers has been directed to the possibility of increased quantities of intra-cranial fluids (lymph, blood, pus) being driven into the space between the nerve sheaths, causing a dropsy of the peripheral end of the nerve, obstruction to its blood circulation, and alterations in its nutrition. According to this theory, owing to increased intra-cranial pressure, partial stasis in the veins, with exudation of the watery parts of the blood into the sub-arachnoid cavity occurs, and this fluid seeking the point of least resistance, finds its way into the lymph space between the outer and inner sheaths of the optic nerves, and by gradual and long continued pressure, causes a dilatation of the peripheral end of the dural sheath, just before it passes into the sclerotic, compressing, at the same time, the pial sheath and the nerve-fibres covered by it.

I will now project on the screen, careful drawings from a case of choked disks, which came under my notice in 1873,[1] when the autopsy showed a sarcomatous tumour of the cerebellum; abundant serous fluid in the subarachnoid space of the brain and spinal cord; pear-shaped dilatation of the outer sheath of the optic nerve, just before it passes into the sclerotic; and markedly swollen disks, which were commencing to undergo atrophy. These pictures, which show first the cerebellar tumour, second the dilatation of the outer sheath of the nerve, third, sections of the nerve, and fourth, teased portions of it, depicting the minute pathological changes in it, will probably give you a more accurate idea of the pathological changes than any verbal description. Similar pathological alterations have been found in many other cases of brain tumour by other observers, and while I am far from asserting that this is the only way in which choked disks can be produced by intra-cranial disease, I do maintain that it is the only method of its production which has been anatomically demonstrated at the present time. Of course local tissue changes in the subvaginal canal or in the sheath of the nerve near its peripheral end, may cause either by direct pressure or the development of local dropsy, an optic neuritis. As illustrations of such local changes hemorrhages into the subvaginal space, and the development of tumours may be cited, and recently Michel has detailed a case where the autopsy showed the development of tubercle at this point.

As to the frequency with which double optic neuritis occurs in cases of brain tumour, there has been considerable difference of opinion. A few years since some distinguished ophthalmologists gave it as their opinion that optic neuritis was a rare symptom of brain tumour. Thus Becker, at the Heidelberg Congress in 1868, gave it as his opinion "that brain tumours frequently occur without any swelling of the disks," and Schweigger, in his Handbook, in 1871, says, "that choked disks are absent in the majority of cases of brain tumour;" recent statistics, however, prove the contrary. I will only cite here those of Annuske and of Reich, and will regard among these only those cases where there was an ophthalmic examination, during life, of such cases; the former gives 43, and the latter 45, making a total of 88 cases. Of these, in 82 cases (*i. e.*, in 93 per cent. of them), there was double optic neuritis. Moreover, Hughlings Jackson, who has probably the largest individual experience of any observer of the present day, declares that optic neuritis is an almost universal accompaniment of cerebral tumour.

Basilar meningitis, especially the basilar meningitis of tuberculous children, is a frequent cause of optic neuritis. Thus Heinzel gives 33 cases of basilar meningitis in children, of which 27 (81 per cent.) showed either neuritis or consecutive atrophy. Allbutt gives 38 cases of basilar meningitis, out of which 29 (or 76 per cent.) showed changes in the optic disks. We thus see that double optic neuritis becomes a valuable symptom of brain tumour and basilar meningitis.

Such cases of course usually end fatally, from the natural progress of the severe malady causing them; but I have seen occasional cases of basilar meningitis in children, where they had escaped with partial or complete atrophy of the optic nerve; and in adults, cases of syphilitic gumma within the cranium, and of cerebrospinal meningitis where there was marked optic neuritis, and recovery with slight atrophy of the disks. I believe that the number of such cases in which double neuritis occurs, is usually much underestimated, simply because it is not carefully looked for, many taking it for granted that it is not worth while to examine the eye-ground unless there is marked failure of vision. It must, however, be recollected that a very considerable swelling and engorgement of the intra-ocular end of the nerve, is quite compatible with good vision. I have followed a case for months where there was marked choking of the disks, and in which the vision remained good $\left(\frac{20}{\text{xxx}}\right)$; and Mauthner cites a case where the patient, to the day of his death, retained perfect central vision $\left(\frac{20}{\text{xx}}\right)$. The ophthalmoscope should therefore be used in every case of suspected brain tumour, whether there be failure of sight or not.

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[1] Transactions of American Ophth. Soc., 1874. Cases of Optic Neuritis, by W. F. Norris, M.D.

Atrophies of the Optic Nerves form a large group of cases arising from very various causes. Of these we will restrict our attention to a few varieties coincident with other nerve lesions.

Atrophy accompanying Locomotor Ataxia.—The exact percentage of cases in which atrophy of the optic nerves is found with gray degeneration of the posterior columns of the spinal cord, and the stage of the malady in which it may be first observed, is not yet well made out. I am inclined to think that it is a much more frequent accompaniment of the early stages of tabetic disorders than is usually supposed. Here, as in cases of choked disk, the acuity of central vision long remains unimpaired, and without careful and methodical examination, the concentric narrowing of the field escapes detection. It is only when this had advanced to a degree sufficient to incommode the patient, and when the central vision commences to fail, that we find them applying to the oculist for relief; and the other symptoms of the disease are usually then so far advanced that they are unmistakable. Moreover, like all early stages of atrophy, it easily escapes observation, even when looked for, unless the observer avails himself of the enlargement given by the upright image, and the nicety in distinguishing slight changes of color possible with the weak-light mirror. While I believe this to be the usual course of tabetic atrophy, the observations of Förster and Charcot prove that complete atrophy of the nerves may develop before any other symptoms are manifest. The former relates a case where, for three years, the atrophy of the optic nerves was the sole symptom of the malady, and then unmistakable symptoms of gray degeneration of the posterior columns of the cord developed themselves. The latter cites a case where atrophy of the optic nerves preceded, for ten years, the development of the other symptoms. Of course in these cases where blindness occurs years before the development of the symptoms of locomotor ataxia, they naturally pass from the observation of the specialist. That the cases of degeneration of the optic nerves accompanying locomotor ataxia forms a large percentage of the total number of cases of amaurosis presenting themselves at an eye hospital, is manifest from the observations of Leber, who reports that in 87 such cases taken as they presented themselves at his clinic, 23 (*i. e.*, 26 per cent.), presented ataxic symptoms; and we may fairly presume that the real percentage is higher than this, inasmuch as it is probable, as in the above cited cases of Förster and Charcot, that spinal symptoms would subsequently develop in some of those cases of amaurosis, in which they were not manifest at the date of examination.

Besides the optic atrophy, cases of locomotor ataxia often, in the earlier stages, develop paresis of the third and sixth nerves, causing transient double vision and dilatation of the pupil. A contracted state of the pupils is, however, more frequent, and we often find them unequal in size, responding more promptly to changes in the convergence and accommodation, than to change from light to shadow.

This state of the pupils may possibly be caused by some affection of the cilio-spinal centre of the cord (at the level of the lower cervical and upper dorsal vertebræ), but I believe that no such lesions have at present been demonstrated by autopsy. The frequent degeneration of the optic nerves in these ataxic cases, is indeed difficult to account for, inasmuch as we have not yet been able to demonstrate any anatomical connection between the gray degeneration of the posterior columns of the cord and the similar affection of the optic nerves, the intervening portions of the cerebro-spinal system being often apparently unaffected by it.

Disseminate Sclerosis of the Brain is also frequently accompanied by atrophy of the optic nerves; and, according to Förster, in about 50 per cent. of these cases, trembling movements of the eyeballs (nystagmus) are observable.

The subject of *Hereditary Disease of the Optic Nerves* is a most interesting one. It has long been known that children are occasionally born with atrophic eye-nerves, but within the last few years Mooren and Leber have both called attention to a group of cases of hereditary optic neuritis developing itself in certain families about the twentieth year, not affecting all the members of a generation, but the males more frequently than the females. The subjective symptoms are a cloud in the centre of the field, while peripheral vision remains good. "The patients belong to the so-called neuropathic individuals of Griesinger, and complain of headache, migraine, dizziness, flashes of light, going to sleep" of the limbs, and convulsive attacks; only one, however, had epilepsy.

Atrophies from Alcohol and Tobacco, in their earlier stages, show symptoms of neuritis in opaque, dirty red disks, with venous congestion, peripheral contraction of the field of vision, with diminished acuity of central vision; in the latter stages we have a bluish-white atrophy. Förster has recently called attention to a characteristic scotoma for red, in cases of tobacco atrophy, showing an ovoid form with its longest diameter horizontal, and lying between the fixation point and the blind spot. I have not had an opportunity of examining a sufficient number of cases since my attention was called to this statement, to have an individual opinion as to its frequency, but in a case examined a few days since, such an ovoid scotoma was readily found on the position indicated; but the long axis of the ellipse formed an angle of about 45° with the horizontal line. There was also concentric diminution of the field of vision.

Atrophies following Loss of Blood.—Although perhaps not properly belonging here are most conveniently treated under this head. Transient blindness, complete or partial, may perhaps be due to anemia of the brain centres, or to partial and temporary palsy of the accommodation, but it is to those appalling cases of double atrophy of the nerves following hemorrhage, to which I here refer. Fries, in his monograph on the subject, gives many cases from the older authors where this has followed bloodletting, but the majority of the recently reported cases, where there have been ophthalmoscopic examinations, have followed hemorrhage either from the stomach or womb. The blindness may commence immediately after the loss of blood, but has usually been noticed from three to fourteen days after it. Jaeger gives two carefully examined cases of it, and the pictures which I now throw on the screen are copied from his atlas; and, show first, the blue degeneration of the nerve which was first observed in each case, and second, the atrophy of the retina and dirty-greenish hue of the nerve which developed in one of them, after severe headache coming on six years after the first examination. The nerve which was frequently examined during the interval had remained up to this time as first seen. Both of these cases were consequent on flooding in childbirth; in one of them the woman had four children, and at each birth severe flooding. The sight commenced to fail after the first hemorrhage, and got worse at each successive labor until she became completely blind.

Samelsohn, who has reported a number of interesting cases, supposes that, where the loss of blood is severe, there is great anæmia of the brain, that it consequently occupies less room in the skull, and that serum exudes from the vessels to fill the vacuum, and that as the patient regains strength and blood is reformed, the increased intracranial pressure drives the fluid into the subvaginal space of the optic nerves and causes neuritis. In other cases a hemorrhage into the sheath of the nerve is assumed as the cause.

For those very exceptional cases where after slight loss of blood there is complete blindness, with but slight changes in the nerves, retina, *and prompt reaction of the pupils to light*, we are obliged to assume some lesion of the optic centres; and Samelsohn attempts to explain it upon the observations of Lussana, Brown-Séquard, Ebstein, and Schiff, that wounds of the brain, especially the anterior prominences of the corpora quadrigemina and of the thalamus opticus, may cause hemorrhage into the mucous membrane of the stomach. Consequently he assumes a central lesion, which produces simultaneously the blindness and the hemorrhage.

All this is however but ingenious speculation, and the true pathology is still to be made out by careful autopsies. Of the changes in the eye-ground in cases of *Insanity*, I have no individual experience. Such changes (paralytic retinitis and optic atrophy) are said to be most frequently encountered in paralytic dementia and the general paralysis of the insane.

With this I will close for the present my remarks on the alterations in the fundus oculi, which are symptomatic of other affections of the system or of disease of important organs, and will, at my next lecture, take up some of the local lesions of the eye-ground in disease limited to the eye itself, such as the changes in myopia, glaucoma, etc. I think I have said enough to convince you that the ophthalmoscope may be made an important aid in the diagnosis of disease in other organs of the body, as well as an aid in pathological investigation, and I hope that each one of you will leave the room determined to make it as constantly your companion as you will the stethoscope and the thermometer.

HOSPITAL NOTES AND GLEANINGS.

Case of Laparo-Elytrotomy.—M. M., aged twenty, primipara, of medium stature, rather fat and flabby habit of body, an ironer by occupation, was taken in labour on Friday, Nov. 22, 1878, about 6 P. M., and was admitted into the British Lying-In Hospital, under the care of Dr. ARTHUR W. EDIS, who furnishes the following report of the case:—

When seen by Mr. Fardon, resident obstetrician at Middlesex Hospital, about 11 P. M., she was in strong labour.

The pelvis was small: the head was felt with difficulty at the pelvic brim, the membranes being intact. Miss Thompson, a midwife, was left in charge of the case. About 4.30 A. M. on Saturday, November 23, the membranes ruptured, but the fœtal head remained arrested at the pelvic brim.

About 6.30 A. M., Mr. Fardon being again called to her, gave chloroform, and endeavoured to apply the long forceps, but could not succeed in getting it to lock.

At 9 A. M., I was sent for. The os was then fairly well dilated, the head presenting at brim in the second position, right occipito-cotyloid. The patient had ankylosis of the right hip-joint, the thigh being considerably flexed.

On examination, the pelvis was found to be small and undeveloped, the diameter not exceeding two and a half inches antero-posteriorly. Before resorting to a more serious operation, as the head appeared to be of moderate size, the application of the long forceps was again attempted, but without success. At this time it was noticed that a huge thrombus was distending the right labium. It was then decided to remove her to the Lying-in Hospital, with the object of securing proper nursing, and other appliances, which were impossible in a room ten feet square.

At 11 A. M., a consultation with my colleagues, Dr. Heywood Smith and Dr. Fancourt Barnes, was held. Our unanimous opinion was, that delivery *per vias naturales*, owing to the contracted condition of the pelvis, and the thrombus in the right labium, even after perforation of the fœtal head and crushing by the cephalotribe, would be attended by extreme difficulty as well as danger.

The question of Cæsarean section or laparo-elytrotomy at once suggested itself; and bearing in mind the danger incidental to the former and the comparative success of the latter on the continent of America, it was decided to resort to this as giving the patient a better hope of recovery. The fœtal heart was plainly audible to the right of, and a little below, the umbilicus: the head was felt resting in the right iliac fossa.

Operation.—At 11.30 A. M., chloroform, and subsequently ether, was administered by Mr. Fardon; the patient lying on her back, with her shoulders elevated. The carbolic acid spray was directed on the abdomen during the operation, and every antiseptic precaution observed. The bladder was emptied by means of the catheter. The uterus being drawn upwards and towards the left side, so as to put the skin in the right iliac region on the stretch, a slightly curved incision was made from a point about half an inch above and outside the spine of the os pubis, parallel to, and an inch above Poupart's ligament, to a point an inch above the anterior superior spine of the right ilium. The several structures met with were divided down to the transversalis fascia. This was then opened, Key's hernia director introduced, and the fascia cut. Any bleeding vessels were secured by Péan's hæmostatic forceps. The peritoneum was separated from the transversalis and iliac fasciæ, and a staff passed *per vaginam* to raise the vaginal *cul-de-sac* as much as possible into the abdominal wound. An incision was then made into the vagina on to the staff, parallel to the ilio-pectineal line, and the opening enlarged by tearing with the fingers. The os uteri was now drawn up towards the right iliac fossa, the long forceps applied to the presenting head, and the fœtus extracted with very little difficulty.

It was a male, living, weighed seven pounds ten ounces, and measured twenty inches in length. The placenta was expressed through the wound; the uterus contracted well. But little hemorrhage occurred throughout the operation. On examining the wound carefully, the bladder was found to be torn somewhat on the right side. A catheter was fastened in, and the wound closed by silk sutures; a pad of lint and cotton-wool being then applied, and kept in position by a bandage.

The patient was much exhausted, but rallied fairly after a short time, every precaution being taken to promote warmth and obviate shock. She regained consciousness, and went on well for about thirty hours; urine passed freely through the catheter. The wound was injected with a weak solution of carbolic acid *per vaginam*, the water flowing out freely through the abdominal wound, the three inner stitches having been removed after the first few hours. None of the fluid entered the bladder, leading to the conclusion that the edges of the rent were in apposition. The nursing arrangements were most thoroughly carried out by the matron (Miss Freeman) and a staff of trained pupils.

About 8 P. M. on the 24th, she began to be restless, and showed symptoms of collapse. Wind was passed freely *per anum*, the abdomen being soft and flaccid; but no symptoms of peritonitis, or of extravasation of urine, supervened.

The temperature only once rose to 102.2 deg. Fahr. The pulse gradually increased in frequency, and, spite of every effort to the contrary, the patient gradually sank and died exhausted at 4.30 A. M. on the 25th, forty hours from the time of operation.

I had arranged everything for a careful *post-mortem* examination, but the husband and mother (Irish) objected so strongly to it, and evinced such fear of its being resorted to, that they insisted on the body being at once removed by the undertaker; consequently, my intentions were frustrated, and I am unable to lay before the profession the exact condition of the structures after operation.

Remarks.—My impression is, that the peritoneum was uninjured; there were no symptoms of peritonitis. Although the bladder was evidently torn, this accident has happened in three other cases where recovery ensued; and I had no reason to believe that any infiltration of urine took place.

The patient was a flabby, unhealthy subject, with very defective rallying powers. The extremities were inclined to be œdematous, and became almost livid under the influence of chloroform.

Had Cæsarean section, or even cephalotripsy, been performed, my belief is that the issue would have been the same. She was emphatically an unsatisfactory subject for operation. The ankylosis of the right hip-joint complicated the operation somewhat, rendering it more difficult than would have otherwise been the case.

The child is living and healthy, and likely to do well. From what I have read of the experience of Dr. Thomas, of New York, as also of Dr. Skene, I believe the operation of laparo-elytrotomy will supersede that of Cæsarean section, and also, in many instances, that of cephalotripsy. —*British Med. Journ.*, Nov. 30, 1878.

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Simple Epileptiform Neuralgia.—The patient was a porter, aged 42, well built, and in fair circumstances, who was admitted into the National Hospital for the Paralyzed and Epileptic, under the care of Dr. CHARLTON BASTIAN. His illness had commenced nine years previously with a swollen face after sleeping in a damp bed. During the early years, the pain does not seem to have been acute. The severe pain commenced in November, 1876, and continued, on and off, till July, 1877, with more or less severity. The onset was sudden; but the first attack was not so severe as some of the subsequent ones. At times, he was almost free from pain. In July, 1877, he had a severe aching pain in the position of the right infraorbital foramen; and in the evening of the same day he had an attack of pain in the supraorbital branch, shooting up over his forehead; this lasted from two to four minutes, and recurred in about a quarter of an hour. In this manner he suffered up till his admission to the hospital in November, 1877.

On admission, it was noted that he suffered from epileptiform attacks of pain in the right side of his face, accompanied by increased secretion from the eye and the nose on that side; the attacks coming on about every fifteen minutes day and night, so intense and agonizing as to prevent him from doing anything except rubbing his face up and down at the seat of pain with a handkerchief during the whole period of his suffering. Each attack lasted from two to four minutes, those at night being usually the longer in duration. The pain began at the infraorbital foramen, and shot up to the eyebrow. The skin of the face was not over-sensitive; but, upon touching the supraorbital foramen, it was extremely painful, and brought on an attack of pain. The pain usually commenced in the right labionasal fold, sometimes just at the root of the hair. It did not extend beyond the supra-orbital branches of the fifth nerve and the superior maxillary, and never entered the mouth; he complained of constant throbbing at the infraorbital notch. Before the pain, there was no increase of cutaneous sensibility on the affected side; and when it passed off, there was no diminution. Between the attacks of pain, there was a saltish taste in his mouth. There was no twitching of the muscles of the face; but during the attacks the patient presented the aspect of extreme agony. In the intervals between the attacks, he was almost free from pain. Hearing and vision were good Any movement or sudden starting on the part of the patient, as also forcible mastication, exposure to strong light, washing the face, or strong or sudden emotion, were sufficient to start an attack of pain. Over the infraorbital foramen, there was a puffy swelling. At the outer angle of the eyebrow, there was a boil, as also opposite the mental foramen. There was also an eczematous eruption covering the right cheek, probably due to the constant rubbing.

He was placed on full diet, and ordered one grain of opium in a pill three times a day. His general health was good when he could obtain good sleep; but he was frequently woke up from sound sleep by attacks of pain. The daily dose of opium was increased gradually to nine, fifteen, and twenty-five grains during the first fortnight of treatment, and not till then was any relief afforded.

By November 27th—*i. e.*, a week after he commenced the daily dose of twenty-five grains of opium—the frequency and severity of the attacks of pain had begun to diminish, and he was a little drowsy at times—not very.

December 5th. It was noted that the attacks of pain were less severe, so that he could speak during the attacks, which he could not do formerly; they were, however, of nearly the same duration. It was observed that, though touching the infraorbital foramen still brought on an attack at most times, this was not the case immediately after the pain had passed off.

During January, the opium was temporarily suspended; but, the pain returning, it was resumed. During February, the attacks of pain being much less severe, Dr. Bastian gradually reduced the daily dose of opium without the knowledge of the patient, until at last it was totally discontinued. By the commencement of March, the severity of the attacks had passed away; there was no pain whatever in the supraorbital region, and below the eye it was very slight, so that he desired to resume his occupation. He was discharged in March, 1878.

Remarks by Dr. Bastian.—From its rarity and peculiar characters, epileptiform neuralgia is a malady to which great interest attaches; and this case presents certain characters specially worthy of attention. In the cases observed by Trousseau, the duration of the attacks was often not more than ten or fifteen seconds, and he says, "one minute at the most." Here, unfortunately for the patient, the duration of the attacks was often two to four minutes, those of the night being rather longer than the day attacks. Trousseau makes no note of increased secretion from the eye and nose, and of suffusion of the conjunctiva and face during the attack, though these features were notable in the present case. The tactile sensibility of the face before and after an attack was carefully tested on several occasions without showing any distinct difference; still it is noted (December 5th) that, whilst a slight touch on the infraorbital region usually at once induced an attack, this same region could be touched even roughly for a short time after an attack without inducing another. A central nutritional change seemed necessary before another attack could occur. As in Trousseau's cases, other causes of the slightest kinds sufficed to bring on attacks, such as chewing a little harder than usual at meal-time, or washing his face, or suddenly coming under the influence of a stronger light, or when feeling any slight emotional excitement. On the cessation of these attacks, the patient became perfectly free from pain. The quantities of opium taken by one of Trousseau's patients was enormous, varying from five to twenty drachms of crude opium in the twenty-four hours. My patient got almost complete relief from a maximum dose of twenty-five grains in the twenty-four hours, which scarcely produced any trace of day-drowsiness, and did not at all depress the general health. Looking to the nature of the malady, I thought it very important that the dose of opium should be diminished whilst the patient thought he was still taking it. Trousseau said that he had never known a single case of this terrible malady to be radically cured; nerve-sections or enormous doses of opium would at times stave off the attacks for three or four months, but then they returned as bad as ever. My patient was submitted to the opiate treatment comparatively early, instead of after years of suffering, so that his immunity from pain may be longer than usual.—*British Med. Journal*, Jan. 18, 1879.

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Acute Eczema treated with Jaborandi.—Harriet T., aged 53, a cook, was admitted Sept. 14, 1848, to St. Thomas's Hospital, under the care of Dr. Ord. She was a fairly nourished, well-developed woman. The skin of the face was scurfy and irritable. Many eczematous patches existed on both arms and legs. The right leg was almost entirely covered with an inflammatory patch, with numerous weeping spots, and studded with small yellowish points. Both ears also were affected. The itching of these parts was very troublesome. In other respects patient's condition presented no points of importance. Her previous history was that of a fairly healthy woman. About three years ago she had varicose ulcers on the left leg, soon followed by similar ulcers on the right leg. These were cured in about thirteen weeks, but broke out again in about two years. During the second attack she had eczema affecting both the lower extremities and the arms. She was then an inmate of this hospital, and was discharged cured in February last. About two months ago she began to feel an irritation about the legs. Five weeks ago there was weeping from the irritated surface, and she became an out-patient under Dr. Ord. Was finally admitted on above date.

Treatment —As local application a lotion of linimentum calcis with albumen was at first employed. Subsequently, on October 4, an application consisting of tinct. catechu and glycerine, each three grains, and water to sixteen ounces, was used On October 12, tinct jaborandi, a drachm in water twice a day, was ordered to be given internally. The following are the notes of the subsequent progress of the case:—

October 8. Legs are certainly better, but the irritation of the eruption on the arm is very great when patient becomes warm. She takes her food better than formerly.

14*th.* Patient is a good deal improved in general health, and as regards the affection of the legs and arms. The posterior region of the scalp and the back of the neck are now affected with eczema.

18*th.* Improvement continues. The dose of jaborandi has been reduced to half a drachm, given twice daily.

25*th.* The legs are now quite dry; the left calf is somewhat tender.

November 15. There has been a fresh attack, of an inflammatory character, of the right leg. The jaborandi has been discontinued for the present.

22*d.* The right leg is much better. Patient is at present taking an iron mixture.

December 10. The jaborandi has been resumed to-day in half-drachm doses, given in three ounces of lime-water. The eczema of the back of neck and scalp does not seem to have been improving lately.

16*th.* The legs are looking clean and do not weep, but the skin is a good deal discoloured. The neck and scalp are much better, and are quite free from discharge. Patient's general condition seems improved.

Remarks.—From observations of the effect of jaborandi in this case, and in other cases of acute eczema, Dr. Ord believes it to be a drug of real value in that disease. It probably produces a hyperæmia of the skin which is favourable to the rapid removal of effete matters, and to an improved nutrition of parts. Very little good has been done in this country with jaborandi as a curative agent, and it will be interesting to know from further experience if it can be relied upon as useful in the treatment of this class of skin affections.—*Medical Times and Gaz.*, Jan. 11, 1879.

Retinitis Albuminurica; Improvement after Premature Confinement; Remarks.—A woman aged thirty-six was admitted on April 18th, into the Westminister Hospital. Her husband was a strong, healthy man, in good circumstances. She had been married eight years, and had had two children; she was pregnant for the third time when she came under observation. There was no trace of syphilis or other inherited disease in her family history. She had enjoyed good health up to within a short time of her admission, with the exception of severe headaches. After an aggravated attack of headache, about the 1st or 2d of April, her eyesight suddenly became dim, and continued to fail day by day, so that on April 12th she applied to Mr. MACNAMARA at the Royal Westminster Ophthalmic Hospital, when, according to Mr. Mackinlay's notes, her vision was *nil* with the right eye; with the left she could make out No. 8 of Snellen's test-type at eleven inches. The urine contained one-half albumen. In both eyes a number of small, raised, white patches were seen arranged concentrically around the upper and outer part of the optic disk, as well as scattered over the fundus of the eye; the retinal vessels could be traced over many of these spots; the margins of the disk were fairly well defined, the retinal veins slightly enlarged, and in many places bright spots of hemorrhage were seen in the retina. Large floating bodies were observed in the right vitreous.

On admission, she could only read No. XX Snellen at four inches; her head was so dizzy she was in constant fear of falling. Under these circumstances, as she was only six months pregnant, Mr. Macnamara urged her to go into the Westminster Hospital, and put herself under the care of Dr. Potter, in order that a premature confinement might be brought on, it being Mr. Macnamara's opinion that unless this means were at once adopted the sight would inevitably be entirely lost. There was also considerable risk of her dying of convulsions during confinement if pregnancy were allowed to run its natural course. The urine at this time contained three-quarters albumen, with a few large and some small faintly granular casts.

On April 27th, Dr. Potter brought on premature confinement, and under his treatment the patient made a very favourable recovery, so that she was able to leave the hospital on May 23d. The urine then contained only the slightest trace of albumen. Six months after she came under treatment she could get about, and perform her household duties. She was able to make out No. 15 Snellen with the right eye, and No. 11 with the left at six inches. No spots of hemorrhage could be detected in either eye, but the glistening patches remained in the fundus of the right eye; in the left they could no longer be seen. The urine contained only a trace of albumen, if any.

Remarks.—This is the third case of the kind Mr. Macnamara has met with, in which rapidly-advancing blindness during pregnancy with albuminuria has been arrested by premature confinement. In the first case the patient retained her sight, and lived for seven years after her confinement, ultimately dying from disease of the kidneys. The second patient is still alive, and has fair sight five years after premature confinement. The case above recorded is the third. In this instance there could, Mr. Macnamara thinks, hardly be any difference of opinion as to the course to be followed, for this patient was pregnant only six months, and the disease in her retinæ was making rapid progress, so that in all human probability she would have become blind in the course of a short time. Moreover, there was less risk to her life during a premature confinement than in labour if pregnancy had been permitted to run on until the ninth month. But in cases of this form of retinitis, in which the sight commences to fail during the seventh or eighth month of pregnancy, the question of a premature confinement is an extremely difficult one. As a rule, the risk under any circumstances is considerable, but the danger to life from convulsions during confinement is generally greater the longer the birth of the child is delayed.

With reference to the sight, every week the confinement is postponed, after symptoms of rapidly-advancing retinitis have declared themselves, the greater the risk of permanent loss of vision, for the destructive changes in the retina are apt to make sudden, frequently rapid, and irrecoverable strides in cases of this kind.—*Lancet*, Dec. 14, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Pneumonia at Bellevue Hospital, New York.—Ten years ago pneumonia was quite uniformly treated with carbonate of ammonia internally and an oiled-silk jacket externally. The carbonate was given in doses of gr. v every three hours, or sometimes gr. x three times a day. The muriate was occasionally substituted. Gradually quinine came to be combined with the ammonia, while now quinine has quite taken its place in many wards. The quinine is given in doses of gr. x three times a day, increased or diminished according to the fever. The oiled-silk jacket is still continued, and if there is much pain in the side, a coat of iodine is ordered. This, with an absolutely recumbent posture, is all that is enjoined in many cases. Aconite has been used in five cases, of which one died. It is given in doses of ♏j every hour, till some effect of the drug in relief of dyspnœa, fever, or production of sweating is produced.

In forty-four cases quinine was used with good results. The method of administration is varied. Besides the routine mentioned, it is given gr. j every hour, or grain v every four hours, and often, as directed by the Juergesen, gr. xl or gr. l in one dose, then discontinuing it for a day or more. The antipyretic effect of quinine is not sufficiently marked to have made it clear which is the best way. Cold sponging has been employed with quinine. Of seven cases so treated, three died. The gradually cooled bath has been used, and at once given up.

Owing to the previous bad habits and bad condition of the patients, as well as to the frequent virulence of the disease, the treatment of many cases of pneumonia soon resolves itself into the treatment of exhaustion, œdema of the lungs, and a nearly moribund condition.

How to carry a patient through critical conditions of this kind, how much stimulus, and what kind, are matters that text-books do not give very definite accounts of, and experience has generally to become the teacher.

Many cases that come into the hospital have a record like the following: The patient is a tolerably strong man, in the third day of the fever. He has a temperature of 104°, respiration 50. His pulse is very good, and he feels pretty comfortable. He is given milk and eggs, and gr. xv of quinine. This is in the morning. In the afternoon he is weaker, his face is a little blue, he breathes faster. On listening to the lungs, moist râles, fine and coarse, are heard. He is beginning to have œdema. He is at once dry-cupped for fifteen or twenty minutes, during which time 150 cups are put on. The œdema has now disappeared. He is ordered ♏x of tr. digitalis every three hours, and ℥ss of whiskey every two hours, with milk and eggs. He continues better for some hours. Towards evening the œdema again shows itself. He is again cupped, and gr. x ammon. carb. is ordered every two hours, alternating with the whiskey. Again the œdema clears up. In addition, a can of oxygen is ordered for the night, and the patient inhales it for fifteen minutes in every hour. This relieves his dyspnœa. But towards morning the cyanosis and œdema again appear. The cups are applied again, and the whiskey ordered. ℥ss every hour, alternating with the ammonia, gr. x every hour. By these measures he is carried through the night, and in the morning is easier. Nourishment in the form of milk is still kept up. He is not allowed to sleep continuously, for during sleep the œdema comes on. By such fighting as this, the greatest reliance being placed on whiskey, milk, and dry cups, a patient is occasionally brought through. If, on the following day, he is still worse, the resources in the way of stimulants are not exhausted. Other forms of ammonia are used. Hypodermic injections of camphor dissolved in sweet oil are given every three hours in four-grain doses. If the patient has persistent œdema and a full pulse, venesection is tried, and is invaluable when digitalis and cups no longer avail. The oxygen cannot be pushed too much, as it causes unconsciousness.

Hypodermic injections of ether to the amount of one or two drachms sometimes bring up the pulse. Teaspoonful doses of champagne every five minutes will help to tide a crisis. There is a limit to stimulation, of course. When ℥ss of whiskey every half-hour has no effect, the patient will die. There is no use in increasing the amount unless it is desired to preserve the stomach afterwards. In the case of a man to whom ℥ss q. ¼ h. was given for several hours, the stomach was found at the autopsy to be considerably hardened by the alcohol, and to smell strongly of it.

In spite of all efforts, most of the cases in which œdema of the lungs occurs go on from bad to worse. The extremities become cold and wet with perspiration; hot bottles applied to them and to the breast, mustard to the epigastrium, accomplish only temporary good, the patient has long been stupid; he now loses consciousness, his breath is slow and laboured, the air-passages are full of serum; gradually the respirations grow slower and slower, and finally stop. The patient dies. At the autopsy part of the lung will be found to have reached the stage of gray hepatization.

It will be seen that no new or specific treatment can be deduced from these cases. It has become a firmly rooted belief that quinine is a good thing to give, and in those so treated the mortality has been somewhat diminished. The class of patients is not one upon which cardiac sedatives can be fairly tried.—*Medical Record*, Feb. 1, 1879.

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Medical Society of the State of New York.—The seventy-third annual meeting of this society was held at Albany on the 4th, 5th, and 6th of February, Dr. D. B. St. John Roosa, of New York, President, in the chair. The meeting was largely attended. A number of papers of great interest and merit were read. The following officers were elected for the ensuing year: President, Dr. Henry D. Didama, of Syracuse; Vice-President, Dr. Nathaniel C. Husted, of New York; Secretary, Dr. Wm. Manlius Smith, of Onondago County; and Treasurer, Dr. Charles H. Porter, of Albany. The next meeting will be held at Albany, on the first Tuesday in February, 1880.

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New Medical Journals.—The following journals have been ushered into existence with the new year:—

The American Journal of Otology, a quarterly journal of physiological acoustics and aural surgery, edited by Dr. Clarence J. Blake, of Boston. The first number contains 80 pages, one-half of which are devoted to original articles, and the remainder to book notices, and a review of the progress of otology and acoustics. The original papers are from the pens of Drs. Blake, Burnett, A. H. Buck, and Sexton, and their names are a guarantee of the value of their contributions.

The first number of the *Index Medicus* has been published. It redeems the promises of its publisher's prospectus, and justifies all that we said of it in our January issue. It is handsomely printed in clear type, on heavy paper.

The *St. Louis Courier of Medicine and Collateral Sciences* is a monthly journal of 120 pages, edited by Dr. A. J. Steele, of St. Louis. Its contents are varied, embracing original communications, societies' proceedings, editorials, correspondence, and extracts from other journals. The first two numbers that have been published are alike creditable to the editor and to the Medical Journal Association of Missouri, under whose auspices it is published.

We have received from G. P. Putnam's Sons, the prospectus of the *Archives of Medicine*, a bi-monthly journal, to be edited by Dr. E. C. Seguin, of New York, and designed to be a continuation of the "Archives of Scientific and Practical Medicine," and of the "American Clinical Lectures." The first number is advertised to appear in February.

FOREIGN INTELLIGENCE.

Protracted Epistaxis Caused by a Parasite.—Dr. LANDON, of Elbing (*Berl. Klin. Wochenschrift*, No. 49, 1878), relates the case of a workman, aged forty-two, who soon after the Franco-German campaign of 1870 was laid up with pain in the hepatic region, jaundice, and gastric disturbance, which symptoms persisted more or less until 1874, when he came under Dr. Landon's care with an attack apparently of perihepatitis. It then appeared that since 1871 he had also suffered from severe attacks of epistaxis, which occurred often twice in the same day. The patient complained of a feeling of painful pressure in the left nasal cavity, but with the speculum nothing but a moderate degree of inflammatory swelling could be detected. Suddenly, at Easter, 1878, a parasite was dislodged from the left side of the nose by a violent sneeze, and from that moment the epistaxis has not occurred. Its cause proved to be the *Pentastoma tœnioides,* a fluke which in the perfect state inhabits the frontal sinuses and nasal cavity of dogs and other carnivora, occasionally of horses and goats, and in some countries of the human subject (Leuckart Küchenmeister). The embryos live encapsuled in the pleural and peritoneal cavity of some herbivorous animals, and invade the liver. After a time they pierce the capsule and wander in the body of their host, finally, unless he dies meanwhile, again becoming encapsuled. If the flesh of the host is eaten uncooked, the flukes find their way in the second host to his nasal and frontal sinuses, where they remain. It is not known how they enter man, but they are found in the liver of the negro. In the present case the hepatic symptoms were clearly traceable to the presence of *pentastomata* in the liver, and their cessation is probably due to the encapsulation of the parasite.—*Med. Times and Gaz.*, Jan. 4, 1879.

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Inhalation of Oxygen in Albuminuria.—Dr. Dujardin-Beaumetz inquired of his colleagues of the Société de Thérapeutique (*Gaz. Hebd.*, January 17) as to the results of their experience in treating albuminuria by means of oxygen. He related a case which had reached its last stage, all means having been tried in vain, when the respiration of oxygen was had recourse to. The albumen disappeared completely during the first twenty-four hours of its employment, and although this disappearance will probably prove only temporary, twelve days have passed without any return. Dr. Constantin Paul replied that he had published two analogous cases, in which, under the use of oxygen, the albumen disappeared, but in two months it returned as bad as ever Similar cases have since been published, and the most that can be hoped for from this means is a comparatively long remission. M. Greletty observed that at Vichy it has long been the practice to administer oxygen both for diabetes and albuminuria, and as a general rule a diminution in the amount of albumen or sugar is observed; but the disappearance is not found to be total, and in all cases is only temporary. —*Med. Times and Gaz.*, Jan. 25, 1879.

Death from Chloroform.—This unfortunate occurrence took place last Friday in Prof. Dumreicher's Clinic in a person to whom chloroform was administered preparatory to an operation for hydrocele. He suddenly expired after the inhalation of from fifteen to twenty grammes of pure chloroform. Every means of recovery, including tracheotomy, were tried in vain. At the autopsy nothing remarkable with respect to the organs of respiration and circulation was found.—*Med. Times and Gaz.*, January 25, 1879, from *Allg. Wien, Med. Zeit.*, December 24.

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A New Test-Paper.—M. Lacour (*Recueil de Méd. Mil.*, August) prepares this by adding to rhubarb double its weight of liquid ammonia, which produces a magnificent red-purple. After a quarter of an hour the liquid is separated by filtering, and strips of filter-paper dipped in it are then dried. Under the influence of acids the paper becomes a lemon-yellow, and with alkalies it regains its former colour. It is a very sensitive test.—*Med. Times and Gaz.*, Nov. 30, 1878.

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Laceration of the Diaphragm from Distension of the Stomach.—In Eulenburg's *Vierteljahrschrift*, Band xxix., is related the case of a man, about thirty years of age, who having eaten a large quantity of food containing vinegar, and taken after it repeated doses of bicarbonate of soda, was seized with violent pain in the abdomen and faintness, and died suddenly. An autopsy having been made, under the suspicion of poisoning, a rupture of the diaphragm, about twenty-five centimetres in length and fifteen in breadth, was found, detaching the diaphragm from the right side of the ribs to the spinal column, and allowing the passage of the intestines and liver into the right cavity of the chest. The stomach resembled an immense bladder distended with gas. The half-digested food had been inspired into the air-passages in large quantities.—*Med. Times and Gaz.*, Feb. 1, 1879.

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Transplantation of Teeth.—A remarkable experiment in the transplantation of teeth is recorded in the *Gazette des Hôpitaux*, No. 2, 1879. On July 30th, M. Pietkiewicz extracted an anomalous right lower lateral incisor which grew under the tongue in a young woman of twenty-six, and planted it in the upper jaw on the same side, in the alveolus of the lateral incisor, which he had just removed for extensive caries, and which was rotated congenitally on its axis. At the same time, by a special apparatus exercising constant pressure, he was able to bring back the right inferior canine into line. In spite of an accident, six weeks later, the experiment succeeded perfectly, the tooth becoming fixed with great firmness. It has been long known to be possible to replace a tooth just removed by another similar to it in regard to age, volume, form, etc., if recently extracted. Indeed, Professor Alquié, of Montpellier, showed, in 1858, that a carious tooth could be replanted after resection of its decayed portion. But it is pointed out that, in M. Pietkiewicz's case, there were very remarkable anatomical differences between a lower and upper lateral incisor. The root of the former is finer, and flattened transversely and grooved; that of the upper is fuller and rounded In fact, the fang of the lower by no means filled the upper alveolus, while at the same time it was considerably too long for it, requiring removal of a third of the crown to bring the edge into line with its neighbours. In spite of all this, the success was perfect, and suggested to the surgeon mentioned the possibility of utilizing anomalous teeth for transplantation, even to replace others not anatomically analogous to them, the difference in shape being remedied by cutting and shaping with instruments. The teeth of other mammalia might also, perhaps, be successfully employed for the same purpose.—*British Med. Journal*, Feb. 1, 1879

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A Foreign Tribute to Dr. Peaslee.—Dr. CHARLES WEST, in his Presidential Address before the Obstetrical Society of London (*Obstetrical Journal of Great Britain*, Feb. 1879), pays the following handsome tribute to the lamented Peaslee:—

"My task is nearly done, and I have but to make mention of two more of our fellows, who held the distinction of our Honorary Fellowship, Dr. Fleetwood Churchill, and Dr. Edmund Peaslee; two men, who though widely different in character, had in common unwearied diligence and unselfish aims, and met their well-deserved reward, not in success only, but in the respect and affection which attended them when living, and which follows their memories now that the grave has closed over them."

Dr. West then gave a brief biographical sketch of Dr. Peaslee, and thus concluded: "Edmund Randolph Peaslee's great claim to our Honorary Fellowship, and the work on which his reputation rests, was his treatise on ovarian tumours and ovariotomy, published in 1872. The book merits and has received very high praise. It is systematic, clear, candid, and takes account of every question which can arise with reference to ovarian disease. The conclusions at which the author arrives are controlled, in large measure, by his own experience, and are always sound and moderate, but, of course, the writer, the total number of whose cases of ovariotomy amounted at that time to only twenty-eight, cannot adopt as decisive a tone as another whose cases are counted by hundreds. Dr. Peaslee's fame, already high, was greatly extended by the publication of this book, and with increased fame came also large increase of practice. There seems, indeed, but little doubt, that his premature death, at the age of 64, was in a great degree owing to the incessant overwork which his practice forced upon him. It was his great good fortune that remarkable as his success was, it yet in his case stirred no enmities, for he seems to have had a special power of personal attraction which drew to him all with whom he came in contact; a charm which our friend, Dr. Barnes, tells me that he felt powerfully on his own visit to America. . . . To have merited and gained so high a name, and such large success, yet never to have stooped to what was unworthy, to have kindled no jealousy, excited no envy, is a happiness which falls to the lot of very few, and is in itself the highest praise."

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HENRY C. LEA, Philadelphia.

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VOL. XXXVII. APRIL, 1879. No. 436

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CLINICAL LECTURES.

ON THE TREATMENT OF DEEP-SEATED ABSCESSES AND ON PERIARTHRITIS.

A clinical lecture delivered at the Hospital of the University of Pennsylvania.

BY JOHN ASHHURST, JR., M.D.,
Professor of Clinical Surgery.

GENTLEMEN: The case which I am about to bring before you to-day is that of a patient who was presented to you a fortnight since, suffering from a very large abscess situated beneath the rectus femoris muscle of the right thigh. The history of the case, as those of you who were present upon that occasion will remember, was that, some weeks before, the patient, a strong, adult male, had received a severe kick upon the front of the thigh, from a horse, this injury having been followed after a time by pain, swelling, and the other evidences of deep-seated inflammation. When the patient was before you, I pointed out, as you will remember, the symptoms which led me to believe that suppuration had occurred, calling attention particularly to the manipulation by which fluctuation was to be recognized —palpating the part in the direction of the muscular fibres, and not transversely —and directing you to notice the existence of subcutaneous œdema, which, I think, is a sign of value as indicating the presence of pus rather than of any other kind of fluid. I did not employ an exploring needle, which indeed is an instrument of which I am not very fond, believing that, in a large majority of cases, careful examination will enable the surgeon to determine the nature of a swelling

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

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without its use; and that, on the other hand, an indiscriminate plunging of exploring needles into tumours of doubtful character, is a proceeding not always quite free from risk.

Being satisfied that we had to deal in the present case with a large, deeply-placed abscess, I spoke to you of the different ways in which it might be opened—as by a free incision (whether with or without antiseptic precautions); by the use of the aspirator; or by the method described by the late Mr. Hilton, of Guy's Hospital, London, which is particularly adapted to cases of abscess occurring beneath layers of muscle, or in dangerous proximity to important structures, as in the anterior triangles of the neck. I confess that I have not been impressed with the reality of the benefits said to be derived from Prof. Lister's method, in its application to abscesses; but in some instances of very large, chronic or cold abscess, there is certainly an advantage in the employment of the aspirator; not that any permanent cure is effected in this way (at least according to my observation), for the abscess cavity fills up again and opens spontaneously after a time, usually in the site of the aspiration-puncture; but by this method you divide the evacuation of the abscess into two stages, as it were, and thus, I think, diminish the shock of the operation.

When, however, you have to deal with very deep-seated collections of pus, and particularly with those which are dangerously close to large vessels or other important parts, you had better have recourse to Hilton's plan. This consists in making a small incision, merely through the skin and superficial fascia, and then thrusting a blunt-pointed, grooved director through the intervening tissues until the abscess-cavity is reached, which may be known by the escape of a few drops of pus along the groove of the instrument; a pair of dressing-forceps is then pushed in, closed, following the director, the blades expanded within the cavity, and the instrument then slowly withdrawn, with a twisting movement, so as to dilate and slightly lacerate the parts, and thus prevent their closing in a valve-like manner before the abscess has fully healed.

Some years ago, I found one morning, among the out-patients at the Children's Hospital, a baby who was cyanosed and evidently at the point of suffocation from tracheal obstruction. Detecting an obscure swelling at the root of the neck, with indistinct fluctuation, I proceeded in the manner which I have just described to you, and succeeded in evacuating a fluid-ounce or so of pus, with immediate relief to the little patient, who thenceforward made a good recovery.

In the present instance I made, as you will remember, a superficial incision, about three-fourths of an inch in length, on the anterior surface of the thigh and over the lower part of the swelling; then pushing a director through the rectus femoris muscle, and enlarging the opening with dressing-forceps, in the way mentioned, exit was given to a very large collection of pus, and we secured the complete emptying of the cavity by gently compressing its walls with moist sponges. I next put in practice a mode of treatment which has been recommended by Mr. Callender, the distinguished surgeon of St. Bartholomew's Hospital, who has recently visited this country, and which I have before now employed with advantage in this room. Mr. Callender's method consists in over-distending the abscess-cavity with a solution of carbolic acid (one part to thirty), injecting the fluid through the small opening by which the pus has escaped, until the part becomes more tense than it was at first, and thus making sure that every portion of the abscess-wall is brought into contact with the carbolized water. A fenestrated drainage-tube is then introduced, and the wound dressed with carbolized oil or, which I employed in this case, a bit of lint spread with the oxide of zinc ointment.

As I told you at the time, this use of carbolic acid is in no respect an attempt to carry out the antiseptic method of Prof. Lister, for it disregards entirely the theory on which his mode of treatment is based, and, as you see, there has been no obstacle here to prevent a whole regiment of bacteria from marching in and out every time the dressings have been changed. I use the carbolic solution simply as a convenient and efficient stimulant to the abscess-wall, and certainly do not attribute to it any specific virtue.

The essential points in the after treatment of a case such as this, are to secure free drainage, and to encourage the adhesion of the walls of the abscess by applying gentle but methodical pressure from the outside. The former object has here been accomplished by the use of the drainage-tube, and the latter by employing pads of oakum with an ordinary roller bandage, which, in careful hands, can effect quite as much as any more complicated contrivance. The drainage-tube, as at first introduced, was, as you will remember, seven or eight inches in length, and was carried by means of a forked probe to the extreme upper limit of the abscess; as the cavity has diminished in size, the length of the tube has been gradually reduced, until now it is little more than a tent, serving to keep the opening patulous. The discharge for the first few days was tinged with blood (a not uncommon result of the application of carbolic acid), but has steadily diminished in amount, so that the patient may now, as regards the affection for which he was admitted to the hospital, be regarded as almost well.

Within the last few days, however, symptoms of another character have manifested themselves, and I bring the patient before you to-day as an example of an affection which is, I think, not very well understood in this country, and a mistake in regard to which may prove the source of much anxiety and annoyance both to your patients and yourselves. A few days ago this patient began to complain of pain in the knee, much aggravated by any movement, either active or passive, and the joint appeared swollen; at the same time there was no constitutional disturbance; the tongue remained clean and moist; there was no fever nor rapidity of pulse, and there was no great tenderness on pressure—certainly much less than we ordinarily meet with in acute joint affections. Remembering the great risk of peri-articular abscesses, of which I have often told you—the danger of their bursting into the joint—and reflecting that the lower border of this abscess was very close to that large bursa or fold of synovial membrane which, as you know, extends upwards for some distance between the rectus femoris muscle and the femur, you might naturally fear that in this case pus had entered the joint and had given rise to an inflammatory condition, which might end in destruction of the articulation, and in loss of limb if not of life.

One simple test, however, enables us to decide this point: had pus found its way into the joint, it would have caused acute synovitis, and rapid intra-articular effusion would have followed. Now, in any case of swelling about the knee-joint, due to the presence of fluid, you can decide whether it is within or without the articulation by pressing on the patella while the limb is extended. If the effusion be intra-articular, you will find that the patella floats, as it were, and by pressure you can make it touch the surface of the condyles, rebounding when the pressure is removed. There is nothing of the kind here; the patella lies firmly upon the condyles and does not change its position even when I tap quite firmly upon it; hence we can feel pretty certain that the swelling in this case is due to changes outside of the articulation.

The affection, then, with which we have to deal, is, I believe, not inflammation of the joint itself, but of the fibrous tissues exterior to the joint, or, in other words, that condition which Duplay, Gosselin, and other French surgeons designate as *Periarthritis*, to distinguish it from *Arthritis* which involves the articular structures themselves. The inflammation in this case is, I believe, due to what surgical writers call "extension by contiguity." Periarthritis may, no doubt, occur in any region of the body, but the only parts in which it seems to have been hitherto definitely recognized are the shoulder and knee, Duplay having described it as occurring in the former, and Gosselin in the latter situation. These gentlemen's papers may be found in the *Archives Générales de Médecine*, for November, 1872, and October, 1873, and since my attention has been called to the subject by reading their accounts of the disease, I have met with it a few times in each of these localities, though I have not observed it in connection with the other articulations. In regard to this, as to many other surgical questions, we find that *facts* have been observed, and well observed, but incorrectly explained, for many years before a true *theory* is suggested. Surgeons have long been familiar with cases in which, sometimes after an injury, but sometimes without any clear history of traumatism, the shoulder-joint has been found painful, with its power of motion impaired, and probably some anterior projection (not very well marked, however), over the position of the caput humeri; and yet in which the most careful examination has failed to detect either fracture or dislocation. These cases were formerly described as instances of "partial luxation," or "sub-luxation," and, though it did not seem very clear why, when a complete luxation was easily reducible, and left no permanent ill-effects, a partial luxation should be so intractable and should cause permanent disability, yet, in the absence of any better explanation, this view was accepted as satisfactory.

After a while, an English surgeon, Mr. Gregory Smith, found in the dissecting-room a number of subjects, in several of which, upon dissecting the shoulder, the long head of the biceps was seen to have given way, while in others it was merely displaced from its normal position in the "bicipital groove." The history of the patients from whom these specimens were derived, was not known, but, some years subsequently, Mr. Soden, of Bath, published a case of obscure injury of the shoulder, in which, the patient dying two years afterwards from other causes, *post-mortem* examination revealed a similar displacement, and from this time "dislocation of the long head of the biceps" became a recognized form of injury with surgical writers and teachers. The accuracy of these *observations* remains undisputed, but the correctness of the *explanation* was after a time called into question by Dr. Adams and Mr. Canton, in England, and subsequently by M. Jarjavay, in France, the British writers regarding the changes in the biceps tendon as secondary to *rheumatoid arthritis*, and the French surgeon considering these cases as examples of traumatic inflammation of the subacromial bursa.

The explanation which I would venture to suggest to you, following the teachings of Duplay and Gosselin, is that these and similar cases should be regarded as instances of *periarthritis*, not necessarily of a rheumatoid character, and, on the other hand, not invariably though often of traumatic origin. The pain, especially on motion, is readily accounted for by the inflamed condition of the tendinous sheaths and bursæ which surround the joint; the loss of motion, which sometimes in the shoulder amounts to absolute paralysis of the deltoid, may be due (in the traumatic cases) to concomitant injury of the nerves supplying the part, or, as suggested by Duplay (in chronic examples), to compression of the musculo-spiral nerve by the products of inflammation; while the deformity is due to effusion into and thickening of the periarticular soft tissues.

Periarthritis undoubtedly presents many analogies, as regards its symptomatology, in both knee and shoulder, to both *rheumatoid arthritis* and the milder forms of *pyœmic joint inflammation*, such as are met with in the so-called *gonorrhœal rheumatism;* and I think it probable that an ardent advocate of what the Germans term "Listerism" might suggest that the case before you was really an instance of septicæmic infection, and that if I had treated this patient with all the minute precautions of the antiseptic method he might have escaped. The objections to such a view are (1) that the affection is limited to a particular joint—that in immediate proximity to the part originally injured, and that which would naturally be implicated in the simple extension of inflammation "by contiguity"—while in septic poisoning we should probably have several joints involved, and this one would be no more likely to be affected than any other;

(2) that the patient has suffered from no constitutional disturbance, and really is not at all ill (which would certainly not be the case in septicæmia); and (3), finally, that, as I have shown you, there is no intra-articular effusion, which, I believe, is invariably present in the joint affections of septic blood-poisoning, gonorrhœal rheumatism being indeed, as remarked by Prof. Bumstead, "essentially a hydrarthrosis."

From *rheumatoid arthritis*, this affection can be distinguished by its affecting but a single part, while the former commonly involves a number of joints, and may sometimes extend to almost all the articulations of the skeleton, being moreover often symmetrical in its development. Rheumatoid arthritis, too, is generally found in persons past the middle period of life, and is most common in the male sex, while periarthritis is met with at all ages and in either sex indiscriminately, all of Gosselin's cases indeed having occurred in young girls.

From the "*hysterical*" joint affections described by Brodie (the "nervous mimicry" of disease, of Sir James Paget), periarthritis can be distinguished by the existence of positive deformity, recognizable both by sight and touch, and by the absence of that intense, superficial hyperæsthesia which is so characteristic of the former affection.

Synovitis could hardly be mistaken for the disease which we are now considering, if any care were taken in the examination of the case; the position of the limb is itself significant in cases of synovitis, the joint being so placed as to allow the greatest mechanical distension of the synovial capsule, whereas in periarthritis, provided that the limb be not moved, one position is not more agreeable to the patient than another. In addition, the swelling in synovial inflammation is obviously intra-articular, and is attended with fluctuation.

In *arthritis*, the swelling is of a doughy character; the joint is usually fixed in the position of greatest relaxation; the pain is much more severe than in periarthritis, and, in the advanced stages, of a "jumping" or "starting" character; and there is much constitutional disturbance, beginning as severe inflammatory fever, which in the progress of the disease assumes a typhoid and eventually a hectic type.

The *prognosis* of periarthritis, as regards the life of the patient, is almost always favourable; unless in some peculiarly unpropitious states of the constitution, recovery may be confidently anticipated. In regard to the restoration of function, we must express a more guarded opinion; if early recognized and carefully treated from the beginning, I believe we may hope for the preservation of the usefulness of the limb, but, if the disease be allowed to assume a chronic form, more or less permanent stiffness is apt to remain. In some cases (in the shoulder) the function of the deltoid appears to be seriously impaired; but even then a useful arm may be obtained, the motions of the scapula compensating for the deficiencies of the affected muscles. The stiffness in the chronic cases is due to inflammatory adhesions of the tendons and tendinous sheaths, and of the bursæ, in the neighbourhood of the joint, but the articulation itself remains uninvolved.

With regard to *treatment*, I have no hesitation in advising you that, in the early and very acute stages, the part should be kept at rest. In the case of the shoulder it will usually be sufficient for the patient to carry the arm in a sling, but in the case of the knee the whole limb should be well supported with a suitable splint or bandage. You see what is employed in this case, a roomy, moulded splint or "gutter" of thick pasteboard, well padded and cut out, or rather *torn* out, around the joint. I say particularly "torn out," because you can make a much better and softer edge by *tearing* pasteboard than by *cutting* it. If there be much pain and tenderness, a soft, warm cataplasm may be placed around the inflamed part; but under other circumstances I prefer what you see here, a mixture of equal parts of mercurial and belladonna ointments, spread upon lint, and applied by gentle pressure made by means of a layer of cotton wadding and a bandage. This you will find very efficient as a soothing and resolvent application; it in some degree corresponds to, but I think is an improvement on, the "Scott's dressing" formerly much employed by British surgeons.

In the later stages, and when the tenderness of the part has disappeared, friction with stimulating liniments may be employed with advantage, and benefit may also be derived from kneading or *massage*, and the use of electricity. In this stage, too, the patient should be encouraged to use his limb cautiously, and as much as may be consistent with the avoidance of increased suffering.

The constitutional treatment, throughout, should be of a tonic and supporting character, iron, quinia, and cod-liver oil being probably the most important remedies.

If the case be first seen at a late period, when the motions of the part are seriously impaired by the formation of inflammatory adhesions, Duplay's advice should be followed, and, the patient having been brought under the influence of an anæsthetic, forced manipulations employed so as to restore the mobility of the limb, when frictions, electricity, etc., may be resorted to as in the earlier stages. The adhesions in periarthritis being altogether *extra-articular*, there is no risk in these manipulations, such as there is in cases of ordinary anchylosis, and, according to Duplay, they are not even followed by any increase of pain.

[Under the treatment employed, the patient's condition quickly improved, the abscess healing without further complication, and the symptoms of periarthritis undergoing prompt amelioration. In a little more than a fortnight the patient was able to take exercise in a wheeled chair, and thenceforward became rapidly convalescent.]

HOSPITAL NOTES AND GLEANINGS.

Notes of Treatment at Hospital for Diseases of the Skin, Blackfriars.—The treatment of diseases of the skin is so often unsatisfactory that the following rough notes of the practice of this hospital may be interesting. The cases described were under the care of Mr. HUTCHINSON and Mr. WAREN TAY.

Lupus Erythematosus.—Patient was a woman of about sixty-nine years of age. Her face was affected on both sides, and there had also been patches of psoriasis about the elbows. She had been attending the hospital since 1876, but the disease remained obstinate. The patient believes that the disease began after exposure to a hot sun in July, 1875. She seemed fairly nourished and stout. The erythematous and non-ulcerative characters of the lupus were well marked The present treatment consists of the internal administration of quinine and arsenic, and the local application of a lotion of glycerine and liquor carbo detergens.

Lupus Vulgaris.—There was one case of this disease. A girl aged about nine years, who was an in-patient, had lupus of an ulcerative character attacking both alæ of the nose, and extending in the form of scrofulous ulceration to each cheek. The patient was markedly strumous. In addition to constitutional treatment, the actual cautery (Paquelin's) was to-day applied to the diseased surface.

Pustular Sycosis.—There was one case of this disease in a somewhat unhealthy-looking man. The pustules were numerous about the cheeks and chin. The local treatment ordered was the application of carbolic acid lotion, and of white precipitate ointment.

Eczema of the Leg; Chronic Ulcers of the Leg.—There were several cases, mostly of a chronic nature, of eczema. The treatment generally adopted was the application of a lotion of liquor carbo detergens (about a drachm to half a pint of water), and of the unguentum creasoti—the former ordered to be kept applied during the day, the latter to be used at night. This form of treatment is very generally successful, so that Martin's pure rubber bandages (which have been recommended in such cases) are not used here. Mr. Hutchinson believes that the confinement of the secretion of the affected parts by these bandages might be useful in cases of old standing eczema where there is great thickening of the skin; but that its use in cases which yield readily to other treatment is not called for. Martin's bandages have been used with great benefit in several cases of chronic ulcers of the leg. They seem to be especially useful when the ulcers are large, flabby, and thick-edged; and, as Dr Martin stated, they enable patients who are unable to desist from their employment to walk about with comfort and without injury. In syphilitic ulcers the local treatment adopted in many cases is the application of the red mercury ointment of the Pharmacopœia.

Porrigo Capitis.—A child was brought to hospital with the entire scalp covered with a dense porriginous eruption. This disease, which might be called porriginous eczema, was generally associated, Mr. Hutchinson remarked, with pediculi, as in that case. The glands at the nape of the neck were enlarged, which was not so in eczema. The secretion from the part was contagious, and the main treatment consisted of entirely getting rid of all incrustation of matter by poulticing and washing and attending strictly to cleanliness, and the use of an ointment of ammonio-chloride of mercury. With care this disease should always be got rid of in a week or two.

Psoriasis.—Among several cases of this disease one was distinguished by the smallness of the patches. These occurred about the face and neck, and were bright red in colour, and only slightly scaly. The parts itched and smarted a good deal. This was in a somewhat acute stage, and the local application ordered consisted of what is called "compound petroleum ointment," and which contains, with other ingredients, chrysophanic acid (ten or five grains to the ounce). This application is somewhat irritating to the skin, and is only applicable where there is no acute inflammation. Arsenic (liquor sodæ arsenitis) was also administered internally.

Lichen Planus.—Two cases of this disease presented themselves. One was about the legs of a middle-aged man; the parts were very irritable, but had passed out of the papular stage. The other case was in an old woman whose arms were affected; there, also, the disease was dying away, but in both the pigmentation was pretty extensive. These cases were treated with arsenic internally, and tar externally, to which they almost invariably yield.

Serpiginous Eruption about Face (Syphilitic).—A young man, about twenty-one years of age, presented himself complaining of a swelling in his throat. He was very anæmic, and all over the face were patches of a copper-coloured eruption, not unlike psoriasis in parts, but traced out in lines about a twelfth of an inch wide. These were arranged in various patterns, some being almost circular, some dumb-bell-shaped, etc. The tongue was ulcerated about its middle and back parts, and there were ulcers about the tonsils. Patient thought he had contracted syphilis in France last September. A chancre had appeared on his penis about seven weeks ago, and about Christmas his face became affected. He thought his tongue had been bad for about five or six weeks. This seemed to be a case of secondary symptoms following very soon on a primary sore—whether this was dependent on the nature of the infection or on the constitution of the patient was a matter of doubt. The treatment was antisyphilitic.

Pityriasis Versicolor.—Chrysophanic acid ointment (five grains to the ounce) has been used with perfect success in the treatment of several cases of this disorder. A lotion of sulphite of soda has hitherto been the general application ordered; and, although the chrysophanic acid is effectual, it seems to offer no advantage over the sulphurous acid.

Ringworm of the Scalp.—Two children, brother and sister, attended. They had ringworm about last Easter, which remained obstinate under other treatment, but had become well under the application of chrysophanic acid ointment. The heads were ordered to be well washed several times a week with soft soap and warm water, and the hair to be kept closely cropped. Another case was associated with kerion, but was also doing well.—*Med. Times and Gaz.*, Feb. 1, 1879.

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Involuntary Rotation of the Head Cured by Continued Pressure on the Neck.—Alice

N., aged twenty-two, domestic servant, was admitted, Sept. 27th, 1878, under the care of Dr. HEATON, to the Leeds General Infirmary. She had a fresh complexion, healthy appearance, rather sturdy frame. There was no history of previous, neurotic symptoms, nor of any such conditions existing in her family. Four years ago, having been overworked after the death of her mother, she began to have tremors affecting the head and the right arm. For this she was treated for four months, in the Infirmary at Kendal, with cold baths and some internal remedies; afterwards she went to the Convalescent Hospital at Southport, but without improvement. Subsequently, she was treated by Mr. Hartley, of Settle, who applied blisters on each side of the spine, after which the movements ceased for six months. Then the movements of the head began, as she was now affected, and they continued till the time of her admission. When she was in the upright position, the head continually rotated rapidly, with about one hundred to-and-fro movements per minute, in regular time. She was quite unable to restrain this movement, except by supporting the head with her hand; it was effected with considerable force, requiring firm pressure to keep the head at rest. When she lay down, the movement ceased. She had no pain, and her general health was good. Menstruation was regular. There was no unnatural movement of the arms, or of other parts of the body than the head at the present time. She was much wearied with the constant movement of the head, which made her neck and shoulders ache.

She was treated medicinally for several weeks, with conium, arsenic, and inunctions of belladonna liniment along the course of the sterno-mastoid muscles, but without any result. Some decayed teeth, which had formerly given trouble, were extracted, with no better success.

In examining this patient one day, Dr. Jacob, the resident physician, discovered that firm pressure with the finger over a spot a little below and anterior to the root of the ear, immediately behind the angle of the jaw, had the effect of completely arresting the movement. This effect was most perfectly and easily produced by pressure on the left side, but on either side the result could be obtained. This effect of pressure in arresting the movement was as prompt and complete as the stopping of a machine when disconnected from the motive force; and equally prompt and decided was the return of the movement when the pressure was taken off. Galvanic currents between the spine and the pressure-points had no effect upon the movements.

An apparatus was subsequently contrived, consisting of a curved steel band fitting on the back of the neck, and having at each end a small pad resting upon one of the pressure-points, and of which the pressure could be regulated by a screw. This she could wear comfortably, and it was quite hidden by a neckerchief. It had the effect, when worn, of completely arresting the rotation, and restoring to the girl the natural control over the movements of her head. She wore this instrument with much satisfaction for some weeks in the Infirmary. When it was removed the movements returned, but she thought they were gradually becoming weaker and less extensive as she continued its use. As she was in good health in other respects, she was dismissed to her home on November 30th, with instructions to appear and report herself at the Infirmary from time to time.

In the middle of January of this year, she presented herself to me at the Infirmary, looking well and cheerful, and possessing the natural control over the movements of her head. She had continued to wear the instrument, with a gradual mitigation of her complaint, until she finally was able to discard its use altogether. Naturally, she was much pleased at being relieved from the discomfort and annoyance of the ceaseless movement of her head, which had troubled her for more than three years. She said that she sometimes had twitchings in her eye and arm, showing some remaining tendency to abnormal mobility of the muscles. She retained the instrument for further use if required by any return of the complaint.

REMARKS.—The curious pathological fact of the existence of points on the surface of the body, by pressure of which some morbid uncontrollable movement can be arrested, has been observed in various instances. One or more such points have been discovered on the surface of the same patient; sometimes these have been symmetrically placed, as in our case—sometimes dispersed irregularly. The point of efficient pressure sometimes overlies the course of the motor nerve of the affected muscles; thus, for example, some convulsive movements of the face have been arrested by pressure over a branch of the trigeminus nerve. In other intances, no such relation can be observed; and this must probably be the case where several pressure-points have been discovered, placed irregularly.

The pressure-points in our case would overlie branches of the cervical plexus, from some of which the muscles concerned in the rotatory movements derive their power. In such case, the suggestion that the pressure temporarily arrests the transmission of nervous vibrations reflected from the spinal centre to the affected muscles affords the most obvious explanation; though it is not equally applicable to some other cases, and though it leaves us quite uninformed as to the nature and the locality of the initial irritation. Morbid involuntary muscular contractions which are *tonic*, stiffening the affected part, are frequently the result of some direct irritation acting on the motor nerve in some part of its course between its spinal origin and the affected muscle; whereas *clonic* spasms, which alternate with relaxations and occasion movements of the part affected, are more frequently caused by reflex irritation; such movements being commonly convulsive and irregular. In ordinary cases of torticollis, for example, the head is habitually drawn to one side, by the constant undue contraction of the muscles on one side of the neck; in some other cases, the morbid action is more convulsive, occasioning irregular jerking movements of the head which are involuntary and emotional; the steady rhythmical uniformity of the horizontal semi-rotations of our patient are a more exceptional phenomenon.

Our object in the use of the instrument which I have described was, in the first place, to provide a means of *relief*, by arresting the movements so long as the instrument was applied. We were not very sanguine of effecting a permanent cure; and the pressure came so near to the course of the carotid artery, that it was feared that some inconvenience might arise from interference with the circulation in the brain. But no such inconvenience was experienced; and the instrument was worn so comfortably, and it so effectually abolished the unnatural movement of the head so long as it was in use, that it continued to be worn habitually by the patient. The very satisfactory result which has followed from its continued use, without the combination of any other means, furnishes an example of the curative effect of a persistent resistance to a morbid action. Here this has been effected, not by any forcible restraint of the moving organ or limb, but by the more subtle means of arresting the exciting influence, which in time has thus been, not arrested merely, but extinguished. The completeness of the present cure of a complaint which has persisted for upwards of three years, and which belongs to a class of disorders which are commonly very intractable, is a remarkable and satisfactory result. As to the permanency of the cure, we must leave the question to be settled by future observation.—*British Med. Journal*, Feb. 15, 1879.

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Fracture of the Skull; Rapid Death; Sugar and Albumen in Urine; Submeningeal Hemorrhage; Hemorrhage into the Bulb and into the Protuberance.

The following case, which was under Prof. VERNEUIL's care at the Hôpital de le Pitié, Paris, is interesting from more than one point of view: first, as a corroboration of certain opinions advanced by M. Duret in a recent work; and, secondly, from the rapidity with which death occurred.

X., thirty-five years of age, mason, fell off the top of a ladder at the height of a second-floor window. He was a powerfully built man, and, as it was ascertained from his relatives, had never been ill previously. It was impossible to learn how the fall had taken place, and what portion of the head had struck the ground. He was immediately picked up after the accident, placed upon a litter, and carried to the hospital. A few minutes after the fall, breathing stopped, and when he reached the wards of Professor Verneuil he had already expired. Three hours after death rigor mortis was hardly perceptible. There did not appear to be any fracture of the limbs, of the thorax, or of the vertebral column. There was no subconjunctival hemorrhage, nor was there any trickling of blood or serosity by the ears. There were traces of hemorrhage by the nasal fossæ. There was no wound of the scalp; the left temporal region, however, was tumefied, and presented a purple colouring. With the help of the catheter, a small quantity of urine was drawn off. By means of heat and nitric acid an albuminous precipitate was deposited, and by the admixture of some of Fehling's solution a large quantity of sugar was shown to exist. The result of the examination of the urine gave rise to the suspicion of the possibility of the existence of a fracture of the skull with concussion of the bulb.

Necropsy, Twenty-four Hours after Death.—Rigor mortis well marked. After the incision of the pericranium, a collection of blood was found in the left temporal fossa. The temporal muscle was triturated and converted into a black pulpy substance. There was a fissure in the bone of the left temporal fossa, extending upwards towards the frontal bone. When the superior portion of the skull was uplifted, a slight collection of blood was found under the dura mater at the point corresponding to the left temporal bone. At the point corresponding to the fissure, which was probably where the shock had been sustained, the pia mater was dotted with traces of hemorrhage. On the right side there was hemorrhage under the pia mater, occupying almost all the surface of the hemisphere, with slight hemorrhagic points. At the base was submeningeal hemorrhage, chiefly situated at the bulb and at the protuberance. Upon section there was no trace of hemorrhage in the lateral ventricles or in the third ventricle. Slight dotted hemorrhage was found in the protuberance, and a small hemorrhagic focus about the size of a pea on the floor of the fourth ventricle, and on each side of the median line two other foci. The hemorrhagic focus on the right side was about the size of a small pea, and seemed to correspond to the point which is described as containing the origins of the pneumogastric nerves. On the left side the extravasation of blood was situated about three centimetres from the median line. There were no traces of hemorrhage in the cerebellum nor in the superior portion of the medulla. The right lung was markedly congested with dark blood. There was subpleural hemorrhage of about twelve centimetres in length, about the middle of the right lung. In the pleura was some black blood coagulated. The left lung was less coagulated. There was subpericardiac hemorrhage on the anterior face of the heart. The heart otherwise was healthy. Liver slightly congested. The kidneys were tolerably congested, especially the right one.

Remarks.—This case showed us hemorrhagic lesions of the meningeal membranes at the base and on the hemispheres at the point where the shock took effect, and at the point diametrically opposite to it, as mentioned by M. Duret, after concussions, and which are probably determined by the shock of the cephalo-rachidian fluid. It showed also lesions of the fourth ventricle, thus explaining the reason of the rapid death; as also the presence of albumen and sugar in the urine, and the congestion and hemorrhage in the different viscera. The lesions of the fourth ventricle are determined by the sudden impulsion given to the cephalo-rachidian fluid, as M. Duret has shown.

M. Redard has already twice observed the presence of sugar and albumen in the urine of patients with fracture of the skull. This case of surgical injury might be compared to those of medical shock (cerebral hemorrhage) where glycosuria and albuminuria are found temporarily accompanied by visceral congestions. M. Redard, while *interne* in the service of M. Ollivier, saw many cases of cerebral hemorrhage where glycosuria and albuminuria had existed during life, associated with congested viscera.—*Lancet*, Nov. 30, 1879.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Topical application of Morphia and Solution in Oleic Acid.—Dr E. W. CUSHING calls attention (*Boston Med. and Surg. Journal*, March 20, 1879) to the advisability of applying, in certain cases, where the hypodermic injection of morphia is objected to, a solution of morphia in oleic acid rubbed over the painful part, and reports a case in which quite severe symptoms of poisoning had arisen after the application of thirty minims of a solution of morphia in oleic acid of the strength of Magendie's solution.

Paracentesis of the Pericardium.—In the number of the *Medical News* for March, 1878, Dr. Pepper published a clinical lecture on Paracentesis of the Pericardium, which contained the report of a case in which the operation had been successfully performed. The sequel of the case, with some interesting remarks by Dr. Pepper, will be found in the current number of the *American Journal of the Medical Sciences.*

Public Health Legislation.—At its last session Congress passed a bill introduced by Mr. McGowan, of Michigan, and approved by the American Public Health Association, "to prevent the introduction of infectious or contagious diseases into the United States, and to establish a National Board of Health," to consist of seven members to be appointed by the President, and of one medical officer of the Army, one of the Navy, one of the Marine-Hospital service, and one officer from the Department of Justice, with power to elect its own president. The Board is empowered to make or have made special examinations wherever it may deem advisable to promote the objects of the act. Its duties are defined to be to obtain information upon all matters affecting public health, to advise the several departments of the government, and the executives of the several States on all questions submitted by them, or whenever, in the opinion of the Board, such advice may tend to the preservation and improvement of the public health.

The Board of Health, with the assistance of the National Academy of Science, is required to report to Congress at its next session a statement of its transactions, together with a plan for a national public health organization, which plan is to be prepared after consultation with the principal sanitary organizations and the sanitarians of the several States, special attention being given to the subject of quarantine, both maritime and inland, and especially as to regulations which should be established between State or local systems of quarantine and a national quarantine system.

Fifty thousand dollars were appropriated to carry out the purposes of the act.

By a clerical error in transcribing, two important clauses were omitted, by which the National Board was empowered to aid in the work of State boards of health, and of State or municipal quarantine authorities, and at their discretion to pay a certain portion, not exceeding one-half, of their expenses, and by which a further sum of five hundred thousand dollars was appropriated to carry out the purposes of the act. It is hoped that these omitted clauses will be restored at the present extra session of Congress.

Subject Catalogue of the Library of the Surgeon-General's Office.—It affords us great gratification to be able to announce that Congress has authorized the printing and binding of the first two volumes of the index catalogue of this library, and that by a clause in the Sundry Civil Appropriaton Bill twenty thousand dollars have been appropriated for that purpose. The manuscript is ready for the press, and the two volumes, each of about 1000 royal 8vo. pages, will certainly be issued within a year. The index will be complete to date.

The New Census.—The last Congress passed a bill providing for the census of 1880, which is of interest to physicians, since it provides for the collection of statistics of disease, as well as of mortality, and under its provisions it is hoped to obtain some very valuable data as to the relations of the more important diseases to locality, occupation, age, race, and sex.

American Medical Association.—The next annual meeting will be held at Atlanta, Georgia, on Tuesday the 6th of May. Dr. Theophilus Parvin, of Indiana, is the president-elect.

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Convention of American Medical Colleges.—In compliance with the resolutions offered by Dr. Gross and adopted at the last meeting of the American Medical College Association (see *Medical News* for August, 1878), a call has been issued for a convention of delegates from all American medical colleges, to meet at Atlanta, Georgia, on Friday, the 2d of May, at 10 o'clock, to adopt some "uniform system of instruction more in harmony with the requirements of the age." One of the proposed questions for discussion is, "Shall all the colleges require attendance upon three regular courses of lectures during three separate years ere admitting students to become candidates for the degree of M.D.?"

The Chair of Theory and Practice of Medicine in the University of Pennsylvania.—On the 4th of March Dr. Alfred Stillé tendered to the Trustees of the University his resignation of the Chair of Theory and Practice of Medicine, in accordance with a resolution which he made at the time of his election not to hold the chair after this date. In his letter of resignation he makes the following remarks on the improved curriculum:—

"I venture to congratulate you on the degree of success which has attended the adoption of an improved medical curriculum, an object for which I have conspicuously laboured from the beginning of my medical life. At the same time I venture to hope that the present success may at an early day lead to an extension of the annual course of lectures to eight or nine months, and of the whole term of study to four or five years, as well as to an examination for admission into the Medical Department. When these changes shall have been made, and not before, will the medical education of the University rank with that of the leading medical schools of Europe."

Immediately upon the receipt of this unexpected resignation, the Trustees appointed a special committee, whose object is stated in the following extract from a letter which they sent to Dr. Stillé:—

"We have been instructed to express to you, as warmly as possible, the regret with which the Trustees heard of your wish to resign your professorship. Their sense of your great services to medical science; your loyalty to the school; their personal esteem, founded on the mutual relations of many years, unite to increase their sense of the loss your resignation would entail upon the University. We desire, therefore, as representing the Board, to ask that you will reconsider your action and gratify us by withdrawing your resignation."

To which Dr. Stillé made the following reply:—

"I have great pleasure in acknowledging the receipt of your note requesting me, on behalf of the Trustees of the University, to withdraw my resignation.

"As I stated in my letter to the Board, I offered my resignation in pursuance of a resolution long ago made. I recognized the policy of the law under which many public officers are retired on reaching a certain age, and I had seen in the medical faculty of the University too many instances of professors clinging to their chairs after they had ceased to be useful, not to feel solicitous that no such stigma should attach to me.

"I had reached the age beyond which I know that 'tis difficult to acquire fresh knowledge and to modify old beliefs, and I therefore felt that my duty to the University required me to withdraw before my pupils should detect any failure in my power of teaching.

"I did not doubt that the Board of Trustees would take a similar view of my act, and perhaps feel relieved by it of any solicitude about the interests of the chair I occupy.

"It would be an affectation to profess that I am not deeply touched by the action of the Trustees which you communicate. It is as gratifying as it was unthought of by me, and really leaves me no alternative but to yield to their wish, and endeavour, in continuing to perform my duties, to justify their courteous and generous action.

"I therefore beg leave to withdraw my letter of resignation, and to thank you for the very gratifying terms in which you have spoken of my relations with the University."

On March 14th the Trustees passed a resolution expressive of their gratification at the withdrawal of Dr. Stillé's resignation, a gratification in which the profession at large will participate.

—

Jefferson Medical College, Philadelphia.—At a meeting of the Board of Trustees of this institution, held on the 18th ult., the professorship of Materia Medica and Therapeutics, vacated by the death of Dr. John B. Biddle, was filled by the election of Dr. Roberts Bartholow, of Cincinnati. Dr. Bartholow is universally recognized as pre-eminently qualified for the position, and the school is fortunate in having this important chair so ably filled.

—

Harvard University.—Dr. Reginald H. Fitz has been elected to the chair of Pathological Anatomy in the Medical Department, vacated by the death of the late Dr. J. B. S. Jackson. Dr. Fitz has been for several years Assistant Professor, and is eminently qualified for the succession.

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Rush Medical College, Chicago. — A Professorship of Gynæcology has been created in this school, and Dr. Wm. H. Byford, of Chicago, has been elected to fill the new chair.

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Medical Directories of Illinois and of the Pacific Coast.—The Illinois State Medical Register for 1878–9 is a comely duodecimo volume of 207 pages, published under the supervision of the Chicago Medico-Historical Society, with the co-operation of the Illinois State Medical Society, and edited by Dr. D. W. Graham. In addition to the lists of physicians in Chicago, and in the State, there is also much information of interest to the physicians residing in the State, such as lists of medical societies, charitable institutions, hospitals, colleges, dispensaries, pension surgeons, etc., and the law regulating the practice of medicine in the State. The volume is well compiled, handsomely gotten up, and is published by Mr. W. T. Keener, of Chicago.

The Medical Directory of the Pacific Coast is an octavo volume of 72 pages, and contains the law regulating the practice of medicine in California, and the list of physicians to whom licenses have been granted, as well as lists of the membership of the Nevada and Oregon Medical Societies, and of the local societies of California, with information of local interest. It is edited by Dr. W. A. Grover, late recording secretary of the California Medical Society.

OBITUARY RECORD.—At Washington, on the 14th ult., in the forty-second year of his age, JOHN MAYNARD WOODWORTH, M.D., Supervising Surgeon-General of the U. S. Marine-Hospital Service.

Dr. Woodworth was a native of New York State, but migrated early in life to Illinois. He studied medicine in Chicago, graduated at the Chicago Medical College in 1862, and shortly afterwards entered the army as Assistant Post-Surgeon at Camp Douglass, Ill. He served through the war, and was promoted to the position of Medical Inspector and Director of the Army of Tennessee. In 1871 he was appointed to the position he held at the time of his death, and the present efficiency of the Marine-Hospital service is in great measure due to his energy and executive ability. It was largely through his exertions that the National Quarantine Act was passed. Recently he has been prominently active in the investigation of last year's epidemic of yellow fever, and in urging national legislation in connection with State Medicine and the Public Health Act just passed by Congress.

Dr. Woodworth was a zealous and efficient public officer, and his death is a severe loss, especially to that branch of the Federal service of which he was the chief.

FOREIGN INTELLIGENCE.

Salicylic Acid Enemata in Dysentery.—Dr. BERTHOLD (*L' Union Méd.*, Jan. 9) employs an enema consisting of one gramme of salicylic acid, 300 grammes of distilled water, and alcohol q.s. In dysentery with tenesmus and bloody stools he administers it every four hours. The tenesmus diminishes, and the number of the stools is rapidly reduced, the fecal matters gradually acquiring their normal appearance, the temperature diminishing, and the appetite returning.—*Med. Times and Gaz.*, Jan. 18, 1879.

Chloroform and Chloral.—From Dr. R. Köhler's report on "The more Important Events in Professor Bardeleben's Clinic at Berlin in 1876" (*Charité Annalen*, 1878), we learn that, in consequence of the occurrence of four cases of death by chloroform, and a large number of unsatisfactory instances of its use in the Clinic, this anæsthetic has been replaced by ether, or by "chloral-chloroform." Since this change accidents have disappeared. The deaths occurred after the inhalation of very moderate doses of chloroform. In the treatment of delirium tremens, on the other hand, chloral has been replaced by morphia, more than half the cases having died of late years under the chloral treatment. With the reinstatement of morphia the mortality appears — and Professor Küster has made the same observation— to have again diminished.—*Med. Times and Gaz.*, Feb. 15, 1879.

Partial Destruction of the Skull.—At the meeting of the Académie de Médecine, on January 18th, M. BROCA presented the upper portion of the skull of a boy, who, notwithstanding the terrible injury, was still alive and well. The patient, a shepherd boy, had always enjoyed good health, but from his birth had presented the peculiarity that, if he once went asleep in the evening, it was impossible to awaken him. He would spontaneously awake in the morning, and go about his work. One evening, having been left sitting on a chair by the fire, he fell asleep, and was found almost in the fire. His large felt hat was smouldering on his head, which had also been burnt; but he had gone on sleeping as usual. He was put to bed, and the next morning awoke and went out to tend his flock, without complaining of any pain. This went on for some weeks, until a large eschar fell off and exposed the bones of the skull, which appeared black and mortified, while a line of demarcation separated the dead bone from the living. One day a sequestrum fell off, which comprised the whole of the external surface and a portion of the diploë of both parietal bones, the upper portion of the frontal, and part of the occipital bone. The temporal bones, which were still covered by their muscles, had not suffered About a year later, the wound began to be covered with granulations. In one particular spot, which corresponded to the middle region of the right parietal bone, pulsations could be felt, which were isochronous with those of the heart. The next year these pulsations had disappeared, showing that ossification had taken place. The wound now is almost as large as it was a year ago, as the cicatrization progresses very slowly; but the boy, although he had lost the greater part of his skull, has continued to tend his flock every day. From time to time, his wound is dressed by covering it with a cloth dipped in oil, over which he wears a felt hat. He often carries heavy burdens on his head, or heavy branches of trees, and is said to rejoice very much at not feeling the thorns, which used to prick his scalp rather painfully when he was in full possession of his skull.—*British Med. Journal*, March 1, 1879.

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The Peabody Donation Fund (*London*).—The report for 1878 of the trustees of the fund of 500,000*l.*, which was given by Mr. Peabody to provide dwellings for the poor of London, has just been published, from which we learn that there has been added to the principal 199,130*l.* 17*s.* 4*d.*, received from rents and interest. The net gain of the past year was 21,963*l.* 11*d.* There has been spent 549,947*l.* 14*s.* 3*d.*, in providing for the artisan and labouring poor of London 5170 rooms, exclusive of bath-rooms, laundries and wash-houses. These rooms comprise 2348 separate dwellings, which are occupied by 9,860 persons. The death-rate in the Peabody buildings for the three years, 1876–8, was 20.76 per 1000, which is about 1.80 in 1000 below the average of all London for the same period.

—

A Digestive.—It is stated by a German naturalist, Herr Wittmach, that the creamy juice of the unripe papaw (*Cerica papaya*), when boiled with tough meat, whether fresh or salted, renders it tender and easy of digestion. Hard boiled eggs are also said to be rendered soft and friable by being digested for twenty-four hours in warm water to which a few drops of the juice have been added; and that, if taken in large quantities without solid food, the juice acts most injuriously on the mucous membrane of the stomach and intestines. In Quito, the juice is smeared over the meat before cooking, and is in very general use; and in Barbadoes, pigs who ate largely of the fruit suffered considerably in health unless they had a considerable amount of other food. The fruit, when fully ripe, is of a bright yellow colour, is seven or eight inches long, and has the flavour of a citron with a slight admixture of turpentine. If the papaw really possess these qualities, the inspissated juice of the unripe fruit would be a valuable addition to our means of treating various kinds of dyspepsia, and be a cheap substitute for pepsine.—*British Med. Journal*, Feb. 22, 1879.

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A Centenarian Bride.—The Polish journal *Kalischania* reports the following extraordinary incident. In the village of Sompolno, in the department of Kalisch in Russian Poland, there lived a Jewish widow named Rajela Wilcznoka, aged 100 years. She lived with her daughter, who was herself 80 years of age, and who was great-grandmother to a child 16 years old. Notwithstanding her great age the widow Wilcznoka walked alone, had good sight, heard perfectly, and had an active mind. She has lately married a merchant, 88 years of age, living in Kalisch. Touching on this subject it is announced that at the time of the last census there were in Austria 183 men and 229 women who had attained or passed the age of 100 years.—*London Med. Record*, Dec. 15, 1878, from *L'Union Médicale.*

—

Obituary Record.—At Paris, on the 12th of January, in the sixty-first year of his age, Ambroise Tardieu, Professor of Legal Medicine in the Faculty of Medicine of Paris.

M. Tardieu was one of the founders of the well-known *Annales d'Hygiène* and the author of the "Dictionnaire d'Hygiène Publique," which is a valuable summary of our knowledge on the subject at the time of its publication.

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ON INJURIES OF THE HAND.

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By P. S. CONNER, M.D.
Surgeon to the Hospital, Prof. of Anatomy and Clinical Surgery in the Medical College of Ohio, etc.

GENTLEMEN: Some of you, perhaps, will remember the patient before us, who a few weeks ago was brought into the house with a compound comminuted fracture of the left hand, and will remember also that at that time I stated to the class that notwithstanding the extent of the injury to the soft parts, and the amount of crushing of the bones, inasmuch as the palm was uninjured and the arterial arches untorn, the probabilities were that the hand could be saved, and a tolerably useful extremity secured.

The loose pieces of bone were, you will remember, picked out, the forearm and hand placed on a well-padded splint, and a plaster of Paris roller so applied as to make proper compression from the ends of the fingers to the elbow, except immediately over the area of laceration. On the twelfth day considerable redness and swelling were noticed on the antero internal surface of the arm. The fixed dressing was removed, and the forearm and hand placed in a tin trough filled with hot water. By the use of this bath, which was kept up continuously for ten days, the inflammation of the forearm was greatly reduced, the pus discharging freely from

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

☞ *In no case is this periodical sent unless the subscription is paid in advance.*

the original wound and an opening made above. The temperature but once during these days rose above 99½° F. Here I may remark in passing, that the hot water bath (to which Prof. Frank Hamilton has in the last few years so strongly called the attention of the profession) has proved in my hands a potent and most satisfactory means of controlling and arresting inflammations of the extremities. The water must be hot, not warm, and the apparatus had better be so arranged that a constant steady inflow and outflow shall be secured.

After removal from the bath, poultices were applied to the forearm and hand for twenty days; since which time the hand has been bandaged with a mosquito-netting roller.

The opportunity now afforded me of showing this case in its present condition, seems a favourable one for calling attention, somewhat in detail, to certain points with reference to the course and treatment of hand injuries; injuries that are very common, often apparently trivial yet productive of most disastrous consequences, and even when most severe justifying attempts to save. Some facts with reference to the anatomy of the hand ought never to be lost sight of. In the first place, the arterial supply is exceedingly abundant, and the anastomoses are very free. Again, one and the same synovial pouch is interposed between not only the two carpal rows, but also the several bones of these rows (for the pisiform should not be regarded as belonging to the carpus), and between three of the four bones of the second row and the four metacarpals that rest upon them. Again, the synovial sheaths of the flexor tendons of the thumb and of the little finger (which latter widens out very much in the palm of the hand) extend upwards above the wrist, and either directly communicate there or are separated by an easily-broken-down partition; while the corresponding sheaths of the flexor tendons of the other fingers near the metacarpo-phalangeal articulations are, by firm attachments of the fascia, cut off from the sub-fascial space. Again, the periosteum covering the terminal phalanges is not a closely-investing membrane, but cribrillated on its palmar surface, through the interstices of which connecting fibres run from the bone below to the skin above, fastening the two together.

Now what influence has each of these anatomical peculiarities upon the effects of injuries. The abundant supply of blood is at once advantageous and disadvantageous. It enables us in very extensive injuries, as in the case just shown, to act conservatively with strong expectations, not to say almost certainty, of saving part and life. Portions of the hand that at first sight may be regarded as hopelessly damaged, will oftentimes, if let alone, prove themselves to be not only capable of living, but of much value in securing a satisfactory result. Very many, if not the majority, of surgeons at the present day, are much of the opinion, as lately expressed by Verneuil, that the knife should never be used in a recent wound of the hand; and even those who are in favour of immediate operation, unite in most strongly insisting that every part that can be saved, shall be saved. The rule here should be just the opposite of that in cases of strangulated hernia. In the latter, you know, "when in doubt, operate;" in the former, when in doubt, *don't* operate. Wait, and let Nature indicate just how much must be lost, be it of the soft parts or bone or both. The disadvantages arising from the character of the circulation in the hand, though much less numerous, are quite as positive. Either as consequent upon the original incision or laceration, or upon subsequent sloughing, one or the other of the palmar arches may be opened, and the hemorrhage is not only great, but oftentimes with great difficulty arrested, because of the very free communication between the radial, ulnar, and interosseous vessels. If you can readily get at the opening, you will, of course, obey the general law, "tie immediately above and below the point of injury," and my own belief is that in cases of primary hemorrhage from either arch, we should make considerable effort, and, if necessary, do considerable careful dissecting to get at the opening and apply the ligatures, and, by the use of the Esmarch bandage such dissection is made comparatively easy. If you cannot ligate, or do not think it best to make the effort to do so, then put on a graduated compress, flex the forearm on the arm, and bandage securely but not too firmly. As you can, each for himself, satisfy yourselves very quickly, putting the forearm in the position indicated will at once stop the radial pulsations. Be sure that your graduated compress is properly made and applied, for unless it is it might just as well, if not better, be dispensed with. Do not use the iron salt (subsulphate or perchloride). It prevents any primary union, and as usually applied does not stop the bleeding. Though this agent has its proper place, and is very useful in its proper place, its indiscriminate employment has done great harm, and I cannot but think that the world would have been better off had it never been introduced into the surgical pharmacopœia.

As a consequence of the peculiar arrangement of the carpal synovial membrane, you can readily understand how rapidly and extensively the carpus may be destroyed by any synovial inflammation lighted up by an injury to the part; for here, as in the tarsus, synovitis, periostitis, and osteitis may follow each other very closely. In the case before us, not only have numerous pieces of broken bone been removed, but at one dressing I took away the scaphoid, semilunar, and magnum, which had become entirely detached

From our present standpoint, the most important of the anatomical conditions to which I called your attention, are the arrangement of the synovial tendinous sheaths and the fibrous communication between the terminal phalanges and the skin of the pulp. In consequence of the latter, a prick of a needle or pin or knife-point, or, as is sometimes the case, a slight contusion, may light up an acute inflammation that will rapidly be carried down along the fibrous bands to the periosteum and the bone; in other words, a deep-seated whitlow (felon) will be the result. In these cases an early and free incision through the periosteum will not in all cases, indeed will not in many, prevent destruction of the terminal phalanx. This is a fact worthy of remembrance, for oftentimes a surgeon is unjustly blamed for the unfortunate result of a case of felon; a very common notion being that if at an early period the periosteum is divided, the knife, as it is said, made to grate upon the bone, death of the phalanx will not take place. It *will* take place in a certain proportion of cases, no matter what is done nor how soon. But the recognition of this fact is no excuse for doing nothing. As soon as it is evident from the swelling and pain that the inflammation has attacked the deeper structures, make a free incision to the bone. If you must err at all, err here on the side of commission, rather than of omission. The operation, as perhaps some of you know, is an exceedingly painful one, though very soon over. It should never, therefore, be made upon an individual in the erect posture; and the incising should always be from behind forwards, so that if the hand is jerked away the movement will only facilitate the cutting. If the phalanx necroses, do not amputate, but simply remove the dead bone; and when recovery has taken place you will find that a very serviceable finger remains, particularly so if, as the result of patient waiting, the bone has been spontaneously loosened, for very often separation will take place at or near the epiphyseal line, and the phalangeal articulation will escape injury altogether.

When from the location of the original injury, or from what cause soever, the inflammation attacks the sheath of a flexor tendon, it is very apt to, indeed may be expected to, run up along this sheath. Where will the pus travel to? If it be the sheath of the thumb-tendon that is the seat of trouble, and prompt relief be not afforded, very soon you will find evidences of deep-seated inflammation just above the annular ligament, extending before long upwards on the anterior surface of the forearm, or downwards into the palm of the hand, or in both directions. If it be the little finger that is affected, a similar condition will be found to exist above the wrist, preceded by or associated with, in the majority of cases, the development of an abscess in the palm. When it is either the index, middle, or ring finger, the flexor sheath of which is inflamed, there will be an arrestation of the disease for a time, greater or less according to circumstances, at or close to the metacarpo-phalangeal articulation. At the expiration of such time, if proper treatment has not been instituted, the barrier between the flexor sheath and the sub-fascial space will give way and a true palmar abscess rapidly form. Such an abscess, however developed, is a most serious affair. The local symptoms are violent, and the constitutional grave. The appearance of the hand is characteristic; the palmar surface convex instead of concave, the fingers flexed at their first joints, the dorsum thickened, œdematous, discoloured. Not infrequently a small sub-epidermal abscess will early show itself, and unless you are on your guard you may mistake this for the real trouble, and, after opening it and giving exit to perhaps only a little turbid serum, flatter yourself and your patient that the worst is over. Left to itself, or treated only with poultices or ordinary fomentations, the disease will not be arrested before irreparable damage has been done to the extremity. *Ordinary* fomentations, I say, for I am strongly inclined to think that by the use of the constant hot bath (as in the case I have to-day called your attention to), great good may be effected. But left to itself, or treated as mentioned, after a protracted period of great suffering, a spontaneous opening will take place, and then another and another; in the palm, above the wrist, on the dorsum, at the root of the thumb, on the inner border of the hand. The inflammation will run up along the connective-tissue planes, the muscular interspaces, to the elbow and beyond, even to the axilla. The carpal articulations may be opened and the bones destroyed. Twice I have had to amputate through the forearm on account of the complete tearing up of the hand in cases of neglected palmar abscess. The bones of the forearm may not escape; and dangerous secondary hemorrhage is not infrequently observed. If the patient's life is saved and the hand preserved, recovery will take place only after weeks, yes, months, of confinement and suffering; if recovery it can be called, the hand thickened, the fingers permanently extended at the metacarpal articulations, and flexed at the phalangeal (the "griffed" hand, having claws, not fingers), the wrist-motions very greatly impaired, if not completely lost. I show you in this man, who has just been brought into the amphitheatre, these very conditions, the original abscess, months ago, having been consequent upon the removal of an enchondroma connected with the first phalanx of the thumb.

In the large majority of cases, though unfortunately not in all, prompt proper treatment will prevent the greater part of the mischief. What is the proper treatment. Early, persistent use of the knife; letting out the pus as soon as its presence is discovered, whenever and wherever it may be found; as it were, heading off the disease by tapping the sheath at the extreme limit of the morbid action. If one incision accomplishes the purpose, so well and so good; if not, cut again, and again, and again if necessary. In making these incisions in the palm of the hand, do not forget the normal position of the "arches," the extreme convexity of which may be expected to lie very little or nothing in advance of a line drawn directly across from the metacarpo-phalangeal articulation of the thumb to the ulnar border of the hand. In a certain proportion of cases (and I have frequently observed it in the dissecting-room), there is no true "superficial arch," but the vessel runs in a slight curve forwards and outwards to near the metacarpo-phalangeal articulation of the index finger. In such cases an incision made apparently in the area of safety, may give rise to troublesome hemorrhage. To avoid injuring the digital vessels and nerves, the cut should be made over a metacarpal bone, and the position of these bones can be readily determined, as you doubtless know, by spreading out the hand fan-wise, drawing lines from the ends of the fingers to the middle part of the wrist, to the interspace, say, between the thenar and hypothenar eminences. When it becomes necessary to give exit to pus above the wrist, or in the forearm, remember that it lies deep, and that there is danger of injuring the median nerve, perhaps the interosseous artery. In these cases I would advise you to operate after the method described years ago by Mr. Hilton, of Guy's Hospital, cutting down to and through the deep fascia, and afterwards using the grooved director and forceps to find the pus and open up a channel for its escape. Though not a brilliant way, it is what is far better for you and your patient—a safe way of operating. Of course, during the whole duration of the case, whether it progresses well or ill, you will have regard to the general as well as the local condition, never losing sight of the fact that, in consequence of the suffering and the suppuration, the patient will progressively become more and more debilitated, and will require careful feeding, very likely stimulation. The best food, however, if I may be allowed the expression, the best tonic and anodyne, is the opening of the abscess and the discharge of the pus. Here, as is not so very seldom the case, "what remedies cannot cure, the knife will." Use it, therefore, quickly and safely; we cannot say pleasantly, even though it does bring relief.

HOSPITAL NOTES AND GLEANINGS.

Case of Athetosis; Death from Phthisis; Post-mortem Examination.—H. B., a tall, thin, gaunt-looking man, a clerk, aged thirty-three, was admitted on January 25, 1877, into the Westminster Hospital, under the care of Dr. STURGIS, in an advanced stage of phthisis. He had for years been afflicted with athetosis. His family history was good, with the exception that one brother had died of consumption. When patient was about three years old he had whooping-cough, and soon after two fits. Respecting these fits he was able to give no definite information, except that they left him paralyzed on the left side. He gradually gained power in his limbs, but the improvement was slow, and when seven years old he could do but little for himself, and was so helpless that he had to be drawn about in a cart. By the age of ten the paralysis had disappeared, and he could run and play about as well as other boys. The athetosis made its appearance soon after the fits, and gradually increased in severity as the patient regained power in his arm. On reflection he was inclined to think that the inco-ordinated movements had not changed much during twenty years, but if there had been any change it was for the better. He stated he had always been very regular and temperate in his habits. He never at any time had incontinence of urine or feces.

The movements referred to were confined to the left side, and almost exclusively to the upper extremity. They were continuous and involuntary. When the hand was extended with the palm downwards, the index and middle fingers were slowly and gradually flexed, the ungual phalanges being first bent, then the middle, and finally the proximal. The thumb was also adducted, and either closed over the first phalanx of the index finger, or passed under the index and middle fingers, so that the ungual phalanx protruded between the middle and ring fingers. The hand was then supinated, the fingers again extended and the thumb abducted. Pronation of the hand completed the cycle. This was the type of the movement, but it was subject to some variation, and there was at times great irregularity. When the fingers were flexed considerable force had to be exerted to extend them, but the forcible extension did not increase the subsequent involuntary movements. Patient had always to keep his nails short, or they would indent the palm of the hand. He was able by a great effort to partly control the movement, but his power in this respect was very slight. On requesting him to close his hand, the fingers being at the time extended, he was unable to do so, and the effort, although directed exclusively to the left hand, often resulted in the unconscious closure of the right. The only time the hand was really quiet was during sleep. The movements were ordinarily so constant and so little under the control of the will that the patient was not able to use his left hand for any of the ordinary purposes of lifting; even his food had to be cut up for him. On testing his manipulative power, it was found that he was just able to lift a quill pen, but that he could not grasp a pin, even when the point was stuck in the table. The movements were perfectly painless, and produced no sense of fatigue. They were not increased by attention being directed to them, nor by any ordinary amount of voluntary muscular movement.

A few years ago patient was recommended to exercise the arm by occasionally lifting a twenty-eight pound weight, and this he found often temporarily intensified the movement. The movement was always increased by worry and trouble, or when he got "flurried" or "upset about anything." Sometimes he overslept himself in the morning, and had to hurry to his business, and this always made him worse. Pleasurable excitement was without any effect. Patient was a theatre-goer, and was fond of playing cards; but these amusements, he said, "never hurt the arm." Smoking kept the hand quiet; it seemed to "ease his mind" and to "soothe it." He was on this account a great smoker, and often on a Sunday afternoon smoked as much as an ounce of the best shag, with, he said, benefit. Tea and coffee in no way affected the movement. A warm bath quieted the movement as long as he remained in the water. He never took cold baths. There was no loss of sensation in either hand. Irritation of the palm with a feather increased the movement when the stimulus was applied to the affected hand, but had no effect when applied to the other. As already stated, the movements were almost exclusively confined to the left hand. Patient said that occasionally his left leg exhibited a somewhat similar condition. This was rarely observed, and only when he was thoroughly tired out with a long walk, and even then it seldom lasted more than half an hour.

The muscles on the posterior aspect of the forearm were much more wasted than those on the anterior aspect; the supinator brevis could not be felt, but the supinator longus contracted well; the extensor ossis metacarpi pollicis and the extensor primi internodii pollicis were the only extensors which stood out prominently, and they evidently acted as flexors of the wrist; both the flexor and extensor carpi ulnaris adducted the hand, and both were to be felt, the former the better; the extensor secundi internodii retained considerable power of contraction; the extensors of the fingers acted very slightly; the extensor carpi radialis longior and the extensor carpi radialis brevior were not visible; on the flexor aspect the palmaris longus and the flexor carpi ulnaris and radialis acted well; there was very little use in the small muscles of the thumb, but the flexor longus pollicis acted well; there was voluntary power of pronation, due to the pronator quadratus, which was small, and to the pronator teres; the flexor sublimis and flexor profundus acted well; the interossei were much wasted. The urine was normal in appearance, free from deposit, sp. gr. always about 1020, no albumen, no sugar.

The phthisis gradually progressed, and patient died on March 19th, the immediate cause of death being diarrhœa and exhaustion.

Necropsy, thirty-six hours after death.—(Present: Dr. Sturges, Dr. Allchin, Dr. Gowers, and others.) — Rigor mortis marked; no post-mortem congestion; great emaciation and pallor of skin. Calvaria rather under than over normal thickness; no local thickenings; dura mater not more than ordinarily adherent; halves of skull symmetrical; dura mater of normal appearance externally; no grittiness of sinuses or vessels; large veins over posterior part of pia mater distended by partially coagulated blood; blood in vessels contained considerable quantity of air-bubbles; Paccionian bodies numerous along posterior part of longitudinal fissure, none in front; no undue thickening of meninges; from three to four drachms of clear serum escaped on removing dura mater. Brain: The whole right hemisphere distinctly smaller than the left, about three-quarters of an inch shorter; the two parietal lobes, viewed from above, were nearly equal, but the frontal lobe on the right side was considerably narrower than on the left; the posterior half of the middle and inferior frontal convolutions, and to a slighter extent the superior frontal and ascending frontal, were distinctly smaller on the right side than on the left. There was a distinct difference also between the anterior portions of the frontal convolutions on the two sides, although this was slighter than in the posterior portions. The occipital convolutions on the two sides were nearly equal, but those of the parietal lobes were distinctly smaller on the right than on the left. There was a depression on the anterior portion of the temporo-sphenoidal lobe about one inch from before backwards, leaving about three-quarters of an inch of the apex unchanged. There was a deep depression extending backwards into the lobe, about three-quarters of an inch deep, and bounded by somewhat atrophied convolutions, on the surface of which some of the white substance of the brain appeared. No difference in size was to be observed between the two halves of the cerebellum; the orbital lobule, like the rest of the right hemisphere, was a little smaller than the left; the right anterior pyramid was very conspicuously smaller than the left. The arteries at the base appeared to be perfectly healthy. Further examination showed that the convolutions of the island of Reil were apparently normal, but there existed on the inner side a deep excavation between the anterior extremity of the perforated spot and the convolutions, extending backwards as far as the level of the corpora albicantia, and extending forwards between the convolutions of the island of Reil and operculum as far as the anterior surface of the hemisphere. Close to the anterior surface of the hemisphere the fissure was three-quarters of an inch deep, and its total length appeared to have been two inches and a half. The sides seemed to have been in apposition, except outside the perforated spot, where the cavity was about a quarter of an inch wide; and its roof was formed by radiating fibres spreading upwards from the pons —probably those of the external capsule. On the inner edge of this fissure the outer root of the olfactory nerve was seen crossing backwards to the temporo-sphenoidal fissure. Ventricles opened: On examination almost the whole of the right corpus striatum appeared to be destroyed —at least that portion in front of the optic thalamus. The posterior portion of the nucleus caudatus outside the optic thalamus was unaffected. A small portion of the inner part of the corpus striatum near the middle also appeared intact, but the whole of the gray substance was destroyed, so that there was only a membranous septum separating the cavity of the ventricle from the deep fissure which has been described. This septum consisted of a double membrane, and in it were seen a number of strands of white fibres, apparently belonging to the internal capsule. The optic thalamus seemed to be quite healthy. No naked-eye change detected in the cord.—*Lancet*, March 15, 1879.

MEDICAL NEWS.

TO SUBSCRIBERS.

In another column will be found an announcement of the death of the Senior Editor of the "American Journal of the Medical Sciences" and the "Medical News and Library," with a brief sketch of his long and useful career. To subscribers it only needs to be added that this event will make no change in the management of these periodicals. For some time they have virtually been under the charge of the Junior Editor, who, in the future discharge of his duties, will feel it to be his highest ambition to maintain the traditions which have rendered the JOURNAL a faithful exponent of the progress of scientific medicine.

ORIGINAL COMMUNICATIONS.

Hæmatoma of the Vulva.—By John W. Trader, M.D., of Sedalia, Mo.

In reading Dr. J. Boronow's case of

Hæmatoma of the Vulva, in the April number of the *Monthly Abstract*, I was reminded of a peculiarly interesting case which came under my notice a few weeks ago.

February 14, 1879, I was called to see Mrs. C., who, it was said, had been suffering all night with a swelling in the groin. I visited the patient in the forenoon, expecting to find a strangulated hernia. Upon examination, however, a large bloody tumour occupied the left labial region, and extending from the lower margin of Poupart's ligament some two inches along the sheath of the femoral vessels, and completely filling up the inguinal space. The history of the case was this: Mrs. C. had given birth to a child some three or four months previous to this occurrence, and without any untoward circumstance. Health naturally delicate, but no hemorrhagic tendency. On the evening before being called in, she engaged in a little friendly tussle with her husband, and apparently "getting the best of him," started to run away, when he threw his foot out and struck her with the toe of the boot in the groin. I found the parts not only very painful, but perfectly livid, and a portion of the vulva gangrenous and friable. After making ready everything, I tore through this sphacelus of the vulva with the index finger, making an aperture into the tumour some two inches in extent and removing a large thrombus, measuring at least a quart. The hemorrhage was quite free and exhaustion imminent. I syringed the cavity well with solution of pernitrate of iron, but it was some time before the bleeding ceased. The dressing of carbolized oil was used, and a sponge compress applied and made secure by a T bandage. No further bleeding occurred and no sloughing beyond the margins of the rent. Under the supporting treatment the patient soon recovered.

DOMESTIC INTELLIGENCE.

National Board of Health.—In accordance with the provisions of the National Board of Health Act, the President has appointed the following as members: Drs. S. M. Bemiss, of New Orleans, H. I. Bowditch, of Boston, Stephen Smith, of New York, H. A. Johnson, of Chicago, James L. Cabell, of University of Virginia, T. S. Verdi, of Washington, and R. W. Mitchell, of Memphis, who with Dr. Bailhache, of the Marine Hospital Service, Dr. Billings, of the War Department, Medical-Director Turner, of the Navy Department, and Solicitor-General Phillips, of the Department of Justice, detailed from the several departments, constitute the Board.

The Board met in Washington, and organized by electing Dr. Cabell, President, Dr. Billings, Vice-President, and Medical-Director Turner, Secretary. An Executive Committee was chosen, consisting of the officers above named and Dr. Smith, of New York, and Surgeon Bailhache.

The Board directed the Executive Committee to employ a commission of experts to make thorough investigations into the causes, conditions, and circumstances influencing the existence and spread of yellow fever in such foreign places as shall be indicated in specific instructions hereafter issued.

The Board will convene in special session at Atlanta, Ga., on Monday, the 5th of May next, and continue in session contemporaneously with the American Medical Association, which meets at the same place on the 6th of May.

The importance of an early interchange of views, and the absolute necessity for consultation with health officers, quarantine physicians, and sanitarians generally throughout the United States, has led the National Board of Health to hold this meeting at Atlanta, and to urge upon all persons interested in matters of sanitation, whether municipal, State, or National, to be present and counsel with the Board. It is earnestly hoped that not only every State, but that every municipality in the whole country will be represented, in order that a step may be taken towards securing a general system of health and quarantine regulations, and, by such a gathering of the prominent sanitarians of the United States, the interests of all sections may be promoted.

In accordance with the provisions of the act directing the National Academy of

Science to co-operate with the National Board of Health in maturing a plan for a National Public Health Organization, the National Academy of Science at its recent meeting in Washington appointed the following committee to confer with the National Board of Health: S. Weir Mitchell, M.D., Chairman: George Engelman, J. Lawrence Smith, Francis A. Walker, J. J. Woodward, M.D., Geo. F. Barker, M.D., Ch T. Chandler, Henry Draper, and Walcott Gibbs.

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National Convention of 1880 *for Revising the Pharmacopœia.*—Dr James M. Morgan, the Assistant Secretary of the National Convention of 1870, has issued the following notice for the next National Convention:—

To the several incorporated State Medical Societies, the incorporated Medical Colleges, the incorporated Colleges of Physicians and Surgeons, and the incorporated Colleges of Pharmacy throughout the United States:

By virtue of authority devolved upon me as the last surviving officer of the Pharmacopœia Convention of 1870, I hereby call a General Convention to meet in Washington, D. C., on the first Wednesday in May, 1880, for the purpose of revising the Pharmacopœia of the United States.

For the information and guidance of all parties interested, I refer them to the rules adopted by the Convention of 1870 to be found on page 11 of the Pharmacopœia of the United States, and request their compliance with the spirit and intention of the said rules.

JAMES E. MORGAN, M.D.,
No. 905 E St., N. W.,
Washington, D. C.

The authority for this call is to be found in the 4th rule, which provides that "In the event of the death, resignation, or inability to act of the President of the Convention, these duties [among which are enumerated the issuing of the call for the next Convention] shall devolve upon the Vice-Presidents in succession; or, should the Vice-Presidents also be prevented from serving, upon the Secretary or Assistant Secretary, the latter acting in the event of the inability of the former.

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U. S. Marine Hospital Service.—Surgeon J. B. Hamilton, of Illinois, has been promoted to the position of Surgeon General, *vice* Dr. J. M. Woodward, deceased.

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Graduates in Medicine in 1879 (continued from page 60):—

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University of Louisiana . . .	32
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Evansville Medical College . .	14

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Professorship of Chemistry in the Philadelphia College of Pharmacy — Prof. Robert Bridges, after a service of thirty-five years, has resigned the Chair of Chemistry in this school, and the vacancy thereby created has been filled by the election of S. P. Sadtler, Professor of General and Analytical Chemistry in the University of Pennsylvania. During the past year Prof. Sadtler has been lecturing very acceptably to the junior class at the College of Pharmacy.

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Rush Medical College.—In addition to the professorship of gynæcology, the creation of which was announced in our last number, the trustees of Rush Medical College, Chicago, have also established a professorship of orthopædic surgery and one of dermatology, and have filled the positions by the election of Dr. Jno. E. Owens to the former and of Dr. James Nevins Hyde to the latter.

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Jefferson Medical College, Philadelphia.—At a meeting of the trustees of this school, held on the 3d of April, Dr. William S. Forbes, Surgeon to the Episcopal Hospital, was elected Demonstrator of Anatomy.

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Meeting of State Medical Societies.—The Arkansas State Medical Association will meet at Little Rock on Wednesday, May 7th.

The Kentucky State Medical Society will meet at Danville on Tuesday, May 13th.

The Colorado Medical Society will meet at Colorado Springs on Tuesday, May 13th.

The Medical Society of the State of North Carolina will meet at Greensboro' on Tuesday, May 20th.

The Illinois State Medical Society will meet at Lincoln on Tuesday, May 20th.

The Medical Society of the State of Pennsylvania will meet at Chester on Wednesday, May 21st.

The Connecticut Medical Society will meet at Hartford on Wednesday, May 28th.

The Ohio State Medical Society will meet at Dayton on Tuesday, June 3d.

The Medical Society of the State of West Virginia will meet at Martinsburg on Wednesday, June 4th.

The Massachusetts Medical Society will meet at Boston on Wednesday, June 11th.

Alabama State Medical Association.—The thirty-second annual session was held at Selma, on the 8th–11th of April, Dr. R. D. Webb, of Livingston, President, in the chair. The following officers were elected for the ensuing year: President, Dr. E. P. Gaines, of Mobile; Vice-Presidents, Dr. Wm. H. Johnson, of Selma, Dr. John W. Sears, of Birmingham.

Dr. Jerome Cochrane, of Mobile, Senior Censor of the Association, was unanimously chosen by the Society as Health Officer of the State of Alabama, as authorized by legislative enactment, and holds his term of office for five years.

Prevention of the Spread of Contagious Diseases. — The Philadelphia Board of Health has ordered that hereafter when death has resulted from a contagious disease, the cause shall be mentioned in published death notice. That the public should avoid unnecessary attendance upon the funerals of those dead from contagious diseases. That among the diseases especially calling for this caution are scarlet fever, measles, whooping-cough, diphtheria, and smallpox or varioloid; and that, whenever possible, air-tight burial cases be used, and if such cannot be obtained the funeral be strictly private.

Complimentary Dinner to Prof. Gross.—On the 10th of April, the medical profession of Philadelphia tendered to Prof. S. D Gross a complimentary dinner on the occasion of the fifty-first anniversary of his doctorate. In memory of the occasion Dr. Gross was decorated with a gold medal, set with diamonds, and bearing on its reverse this inscription: "Presented to Dr. S. D. Gross by his medical friends in commemoration of his fifty first year in the profession, April 10, 1879." A number of distinguished members of the profession from distant cities were present, the occasion passed off with great *éclat*, and Dr. Gross was the recipient of congratulations on every hand.

Stevens Triennial Prize, 1882.—This prize, established by Alexander H. Stevens, M.D., amounts to two hundred dollars. The subjects for the next prize are as follows:—

I. *Lesions of the brain, in connection with the two forms of diabetes.*

II. *Diphtheria, in its relations to membranous croup.*

According to the terms of the prize, the competing essays, on either of the above subjects, should give an account of our present knowledge, and also the results of personal investigation. They must be transmitted to the President of the College of Physicians and Surgeons, New York, on or before the first of January, 1882. Each essay must be designated by a device or motto, and must be accompanied by a sealed envelope, bearing the same device or motto, and containing the name and address of the author. The envelope belonging to the successful essay will be opened, and the name of the author announced, at the Annual Commencement of the College in March, 1882. This prize is open for universal competition.

Obituary Record.—Died in Philadelphia, on the 12th of April, Isaac Hays, M.D., aged 83 years.

Dr. Hays was born in Philadelphia, July 5, 1796, was educated at the University of Pennsylvania, and graduated in the Department of Arts in 1816. He then entered upon the study of medicine in the Medical Department as an office student of the late Prof. Nathaniel Chapman. He received instruction from the lectures of Professors Physick, Wistar, James, Coxe, Dorsey, Chapman, Hare, and Gibson, and graduated in medicine in 1820.

In February, 1827, Dr. Hays joined the editorial staff of the *Philadelphia Journal of the Medical and Physical Sciences*, which was started in 1820 by Prof. Chapman. In November, 1827, with a view to making the Journal more broadly representative and national in character, the co-operation of the leading medical minds in all parts of the country was secured, and the name of the "Philadelphia Journal" was changed to the AMERICAN JOURNAL OF THE MEDICAL SCIENCES: Dr. Hays became its sole editor, and for over half a century it remained under his control.

The increasing progress in the cultivation of the medical sciences gradually seemed to call for more space and more frequent communication with readers, and in 1843 the MEDICAL NEWS was commenced as a monthly in connection with the Journal. This sufficed for many years, until the increasing pressure of material led, in 1874, to the issue of another periodical—the MONTHLY ABSTRACT OF MEDICAL SCIENCE—under the same editorial supervision.

It can be truly said of Dr. Hay's editorship that it was his life's work. His estimate of the editorial functions was lofty; he felt deeply its responsibilities to science and to the profession, and his purpose was unwavering to discharge its duties without fear or favour. An enemy to charlatanism in all its myriad forms, his scrutiny was keen to detect it in every disguise, while his high sense of personal independence led him to unmask it without acceptance of persons, and to serve the best interests of the profession with all the fervor of conviction. His editorship to him was always a labour of love, and neither an onerous private practice nor his numerous other engagements could distract him from it. With advancing years however he sought relief from pressure which was beginning to overtax his strength, and in 1869 he associated with him his son, Dr. I. Minis Hays. Though for the last few years increasing age forced him gradually to relinquish active participation in the editorial control of the Journal, he never ceased to look upon its career with pride, and to the last his interest in it was paternal and undiminished. The one hundred and three volumes of the Journal must stand as an enduring monument of his rare capacity as a journalist, and his unbroken fidelity to his own high standard of the profession of his choice.

From the beginning of his professional career Dr. Hays paid special attention to the diseases of the eye, a field which up to that time had been very little cultivated, and on the organization of the Wills [Ophthalmic] Hospital in February, 1834, he was elected a member of the Surgical Staff, a position which he retained until 1854, when the demands upon his time of private practice compelled him to tender his resignation.

Dr. Hays was earnestly interested in all that concerned the welfare of the profession, and was an active member of several of its societies. He was prominent in the organization of the American Medical Association, and of the Pennsylvania State Medical Society. He was the first Treasurer of the Association and Chairman of its Committee which framed and reported its Code of Ethics, which has since been adopted by every Medical Society in the Union, and is regarded abroad as a standard of professional conduct. On the organization, in 1870, of the Ophthalmological Society of Philadelphia, Dr. Hays was elected its first President.

In early life he became deeply interested in natural history: in 1818 he was elected a member of the Academy of Natural Sciences of Philadelphia, and in 1865 he was chosen its President, which position he retained until December, 1869, when advancing years compelled him to decline re-election. He was an honorary member of numerous societies, both at home and abroad.

In 1828, Dr. Hays edited an edition of Wilson's *American Ornithology*, 3 vols. 4to.; in 1831, he published a translation, made in connection with the late Dr. Robert Eglesfeld Griffith, of Broussais *On the*

Phlegmasiæ, 2 vols. 8vo.; in 1834, he edited the *American Cyclopædia of Practical Medicine and Surgery*, 2 vols. 8vo., and was the author of a number of the articles contained in it; in 1846, he edited Hoblyn's *Dictionary of Medical Terms;* in 1848, Arnott's *Elements of Physics;* and in 1847, Lawrence's *Treatise on Diseases of the Eye*, with numerous additions, which passed through three editions. He contributed to the *Proceedings of the Academy of Natural Sciences*, and to the *Transactions of the American Philosophical Society*, and he was also the author of a number of articles published at various times in the *American Journal of the Medical Sciences.*

Of Dr. Hays's character, as this Journal was so intimately allied with him, we feel that it is not for it to speak.

At a special meeting of the College of Physicians, held April 15, to take action with reference to the death of Dr. Hays, the following resolutions were unanimously adopted:—

"*Resolved*, That the Fellows of the College deeply regret the death of their late able and distinguished associate, Dr. Isaac Hays.

"*Resolved*, That having in view the welfare of the College, he took throughout his fellowship a watchful and active part in its proceedings, and while health and vigour permitted was unusually constant in his attendance at its meetings.

"*Resolved*, That as a member of the Building and other committees, and by his general participation in its affairs, he rendered signal service to the College, contributing greatly to its prudent and conservative policy, and leaving upon all that he said or did the impress of his cautious and deliberative mind.

"*Resolved*, That he has largely contributed by his long and able editorship of the *American Journal of the Medical Sciences*, and by his other valuable works, to the creation and diffusion of a sound and healthful medical literature, and thus made himself, in an enviable degree, an instructor and benefactor of his profession.

"*Resolved*, That by his faithful services of twenty years in connection with Wills Hospital, and by his various publications on ophthalmic surgery, he gave a wholesome impulse and direction to that department, and won for himself a distinguished place among the oculists of the country.

"*Resolved*, That the Fellows, appreciating his learning and his worth, and grateful for services cheerfully rendered during his long and pleasant association with them, will ever cherish a kind and affectionate regard for his memory."

In moving the adoption of the resolutions, Dr. Samuel D. Gross made some remarks eulogistic of Dr. Hays, speaking of the *American Journal of the Medical Sciences*, of which he had been for so many years the editor, as a monument of his industry and learning, no word in which was unworthy of the highest conception of the functions of the editorial chair.

Died at Philadelphia, on the 30th of March, aged 82 years, George B. Wood, M.D., President of the College of Physicians of Philadelphia and Emeritus Professor of the Principles and Practice of Medicine in the University of Pennsylvania.

Dr. Wood was born in Greenwich, Cumberland County, New Jersey, March 13th, 1797. He was educated at the University of Pennsylvania, where he graduated in 1815 with the degree of A.B., and in 1818 with the degree of M.D. He was Professor of Chemistry in the Philadelphia College of Pharmacy from 1822 to 1831, and Professor of Materia Medica in the same college from 1831 to 1835. On the 6th of November, 1835, he was elected to the Professorship of Materia Medica and Pharmacy in the University of Pennsylvania. In 1850, Dr. Chapman resigned the Professorship of Practice at the University, and Dr. Wood was transferred to it in May of the same year, and he held it until his resignation in 1860. In 1863 Dr. Wood was elected a Trustee of the University. He was Physician to the Pennsylvania Hospital from 1835 to 1859, President of the College of Physicians from 1848 to his death, and President of the American Philosophical Society from 1859 to the same time.

Dr. Wood was the author of several works which have taken rank among the classics of our literature. His first important work, the "Dispensatory of the United States," was written in conjunction with Franklin Bache, M.D., and the original edition was published in Philadelphia, in 1833 (8vo., 1073 pages). This work at once stamped him as a man whose research and knowledge of his profession were of the highest order. It went through thirteen editions, the last being in 1870.

In 1847 he published a "Treatise on the Practice of Medicine" (2 vols. 8vo). It ran through six editions, the last being in 1867. He also published, in 1856, a "Treatise on Therapeutics and Pharmacology," or Materia Medica, which went through three editions, the last being issued in 1868 (2 vols. 8vo., pp. 1848).

In 1865, Dr. Wood endowed the Auxiliary Faculty of Medicine in the University of Pennsylvania, consisting of five chairs: respectively, Zoology and Comparative Anatomy, Botany, Geology and Mineralogy, Hygiene, and Medical Jurisprudence.

Although retired from active professional service for some sixteen years, the death of Dr. George B. Wood removes another of the long line of worthy names that have given this city its eminence among medical schools.

Dr. Wood left a large estate, and his will contains the following bequests :—

To the College of Physicians of Philadelphia his medical library, $5000 absolutely, and $10,000, the interest of which is to be expended for the uses of the library.

To the University of Pennsylvania his pathological cabinet; $50,000 for the endowment of the Auxiliary Faculty of Medicine; his Botanical collection and $5000 for the establishment and support of a Botanical Garden, and his residuary estate to the University of Pennsylvania, and $75,000 for the endowment of the "Peter Hahn ward" in the University Hospital.

At a special meeting of the College of Physicians, held April 1st, the following action was taken in reference to the decease of Dr. Wood:

The Fellows, assembled at the call of the College on the occasion of the decease of their late President, Dr. George B. Wood, respectfully offer to the memory of that excellent, venerated, and distinguished man the homage of their profound sorrow and regret.

Resolved, That in his death they mourn not only their own loss, but that also of the community in which he lived, the country to which he belonged, and the profession which he adorned; for his fame, his virtues, and his services, coextensive with all, were the common property of all, and shed a lustre upon the American name and character.

Resolved, That by this sad event they lose a Christian gentleman, refined, courteous and sincere, kind, benevolent, and considerate; one, who though not unconscious of high achievement and desert, was yet modest and unassuming in disposition and demeanour; of elevated walk and noble aspirations; and upright, honourable, and consistent in all his conduct during a long life closed amid universal sympathy and regret.

Resolved, That assuming from the beginning of his career a prominent rank as a teacher of medicine, he greatly improved upon the existing modes of instruction by introducing in the institution, when natural objects were unattainable, the system of pictorial representation; and by his exactness, order, and exhaustive treatment of every topic fixed the attention and enlightened the minds of the students, while by his pure moral principle, exemplary life, and blameless deportment, he imbued them with his own deep sense of the dignity of man, and the honour, usefulness, and responsibility of their profession.

Resolved, That the literary world is deprived, by his death, of a scholar of rare and varied attainments; well read not only in medicine and its collateral sciences, but who was also thoroughly versed in many departments of polite and general literature; to several of which he made interesting and valuable contributions.

Resolved, That he was not only a memorable example of high moral worth and refinement, but also of patient, persevering, and well-directed industry. His mental characteristic was not genius properly so-called; but he possessed capacity of a high order, and had a methodical and mechanical mind, a striking feature of which was its strong, masculine common sense. With this was united the greatest, perhaps, of all talents, steady and unwearied application. It is no doubt true that the man is yet unborn who duly weighs an hour, but Dr. Wood made a much nearer approach to that estimate than is done by most others; diligently improving the fleeting moment, "having wisdom with each studious year;" and always seeking to benefit mankind by lessening the sum of human suffering, and increasing the resources and extent of professional skill. It was a rule of his life, not only to be always busily employed, but to be always usefully so.

Resolved, That these and many other attributes of person, heart, and mind made him emphatically a representative man—one to whom all willingly accorded primacy of merit and position, with fullest confidence in his rectitude, wisdom, knowledge, zeal, and ability. He was an able, ready, dignified, and impartial presiding officer, both of the College and other bodies; a skilful and sagacious physician; a learned professor; an eloquent and instructive lecturer; an eminent author, whose works have contributed greatly to the advancement of medical science; a munificent patron of the profession which he loved; a wise and prudent counsellor; and, withal, a warm and unwavering friend. Seldom has there been found in one person such an assemblage of qualities, fitting their possessor to be a leader of men, and causing him to be regarded *ante alios omnes præstantissimus.*

FOREIGN INTELLIGENCE.

The Propagation of Syphilis by Toys.—M. Galippe has published in the *Journal des Connaissances Médicales*, for January 30th, some remarks on the propagation of syphilis through the various trumpets, whistles, and other toys, sold in the streets by itinerant hawkers, who not only allow every purchaser to try them, but also, if the latter fail to perceive their peculiar properties, perform on them themselves and hand them to the customers without wiping them. In this way (especially about Christmas), hundreds of people, both adults and children, try one instrument after another, laying each down without wiping it. It is easy to see how rapidly the infection may be spread in this way, attacking healthy persons. Some of these toys, especially little balloons which are inflated by blowing into them and which in allowing the air to escape produce some sound, pass through the mouths of three or four workmen before they are sold to the public. The author therefore advises parents never to let their children have any toys which have not been thoroughly cleaned.—*British Med. Journal*, Feb. 22, 1879.

Dermatophony.—The introduction of the microphone for the purposes of surgical diagnosis by Sir H. Thompson, and in Germany by Professor Maas, has led Professor Hueter, of Greifswald, to try whether it would not be possible by its means to detect certain sounds, whose existence may be *à priori* asserted, but which are inaudible by ordinary means. In the *Centralblatt Med. Wiss.*, Nos. 51, 52, 1878, he has proved that we can not only hear the rush of blood through the capillaries of the skin (dermatophony), but also the sounds of muscular contraction (myophony), of tendinous extension (tendophony), and of the vibration of the long bones when percussed (osteophony). Of these the first application is the most curious and interesting. Hueter had observed, without the aid of the microphone, that if he pressed the tip of one of his fingers firmly into the external auditory meatus of his ear he heard a peculiar humming sound (*Bransen*), which was absent if a simple plug of wool or cork was used instead of the finger. With Edison's microphone, provided with a horizontal plate, he detected the same "murmur" on placing the finger-ends on the wooden disk of the instrument, and he was able to convince himself that it was not due to the friction of the fingers on the disk, the sound produced in this way being of altogether a different quality. The final proof that the murmur was really of hæmic origin, and dependent on the flow of blood through the vessels of the skin, was afforded by applying Esmarch's elastic band to the finger, and examining the bloodless part with the microphone. With the exclusion of the blood the murmur ceased.

As the microphone is not easy to apply to the skin of the body generally, and as, wherever the blood circulates, similar murmurs probably exist, Professor Hueter invented a special instrument or dermatophone, consisting of a flexible stethoscope with a thin caoutchouc membrane stretched over the end applied to the skin, and a perforated horn plug to fit the ear and close the meatus as completely as possible. With this instrument, which is supplied for half-a-crown by Weinberg, of Fischstrasse, Greifswald, Hueter has proved that the capillary murmur is most clearly heard where the circulation is most vigorous—namely, on the cheeks and at the finger-tips. In acute inflammation of the skin with marked inflammatory hyperæmia the murmur is louder, but deeper in tone than in the normal state. In venous stasis—*e. g.*, in the neighbourhood of ulcers of the leg—it is weak, and over extensive scars it is entirely absent.

The "tone of muscular contraction" is heard by pressing the dermatophone firmly on the overlying skin. It is deeper and duller than that caused by the tension of its tendon when the muscle contracts.

The percussion of a long bone—for example the ulna, using for this purpose a small hammer with a whalebone handle, and placing the dermatophone on the smooth surface of the olecranon—gives a series of tones which vary as the bone is percussed from below upwards. These tones appear to depend on vibrations of the thin cortical lamellæ, and of the osseous bundles of the spongy portion. Professor Hueter promises soon to enter into the practical value of these methods of examination, in an article in the *Deutsche Zeitschrift für Chirurgie.—Med. Times and Gaz.*, Feb. 25, 1879.

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Pyrogallic Acid as an Antiseptic.—In a recent number of the *Lyon Médical*, Dr. Bovet, of Neuchâtel, calls attention to the antiseptic properties of pyrogallic acid. According to Pasteur, the presence of oxygen is necessary for the development of bacterium and monas; when the supply fails they die and are replaced by vibrios. In short, organized ferments require oxygen, which they obtain either from the air or from water. Dr. Bovet has thought that possibly substances which absorb oxygen might have antiseptic properties; in other words, that substances having an avidity for oxygen might, as it were, asphyxiate the organisms. Pyrogallic acid (or pyrogallol) has a great avidity for oxygen; a weak solution injected into the blood, according to Personne, causes death, probably by deoxidizing the blood. Dr. Bovet has used in his experiments portions of the pancreas of the ox and solutions of pyrogallic acid in pure water; and has arrived at the following results from a large number of observations: 1. A solution of 1 or 2 per cent. prevents for some months the development of odours and of microscopic organisms. 2. A solution of 2½ per cent. removes the odour from fluids in a state of putrefaction, and destroys the bacteria. 3. A solution of 3 per cent. renders motionless and kills all the elements of the *bacillus subtilis*. 4. Pyrogallic acid prevents alcoholic fermentation and the formation of mould. 5. A 2 per cent. solution may be applied locally to man without injury, and is a very good disinfectant. The acid, however, blackens steel instruments, and these stain the hands; the stains, however, may be removed by oxalic acid, and the instruments may be cleaned by washing them in a concentrated solution of soda.—*British Med. Journal*, Feb. 22, 1879.

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The Use of Forceps, and its Alternatives in Lingering Labour.—The Council of the Obstetrical Society of London have made arrangements for holding a discussion on this subject. The debate will be opened by Dr. Barnes at the meeting of the Society to be held on the 7th of May.

—

Death from Chloroform.—A case of this is reported in the *British Medical Journal* for March 29th. The deceased had inflammation of the lungs.

NEW MEDICAL BOOKS—Now Ready.

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THE PRINCIPLES AND PRACTICE OF GYNÆCOLOGY, for the Use of Students and Practitioners of Medicine. By **Thomas Addis Emmet**, M D., Surgeon to the Woman's Hospital, New York, etc. In one large and very handsome octavo volume of 856 pages, with 130 illustrations; cloth, $5; leather, $6.

It may be said that he has had opportunities for observation and experience, for unfettered and unrestrained experimentation, and for testing the value of the original and dazzling operations first proposed and performed by his illustrious predecessors before referred to, and for devising new operations and discovering pathological causes never before suspected or described, which no man in the profession has ever before secured. We also think that the readers of this work will agree with us, after its careful perusal, that he has a rare capacity for discriminating analysis, and generally for philosophical deduction and the equally important quality of patient, honest, continued work. For the work as a whole, we have only praise. It deserves and will receive the careful study of all who desire to keep on a level with the progress of Gynæcology. It embodies a larger amount of carefully analyzed personal experience in a unique field for observation than any volume on Diseases of Women which has yet been published. Its great merit consists in this—coming as it does from a thoroughly honest, competent. and able specialist, who became a specialist only after an excellent training and experience as a general hospital physician and surgeon. The book is not one to be hastily glanced over, but will secure the critical study of Gynæcologists. Not only its style, which is individual and somewhat peculiar, but the new facts which it brings out, its original suggestions, its numerous and important statistical tables, and, in some instances, its unexpected deductions, will compel attention, and will form the basis for a great deal of Gynæcological study and literature in the future. All who make themselves familiar with the contents of this volume, will feel assured that Dr. Emmet has well earned and well deserved the reputation which he has already won, as one of the great Gynæcologists of the present age.—*The Am. Journ. of Obstetrics*, April, 1879.

HABERSHON ON THE ABDOMEN.

ON THE DISEASES OF THE ABDOMEN, COMPRISING THOSE OF THE STOMACH, and other parts of the Alimentary Canal, Œsophagus, Cæcum, Intestines, and Peritoneum. By S. O. **Habershon**, M.D., Senior Physician to and late Lecturer on the Principles and Practice of Medicine at Guy's Hospital, etc. Second American, from the third and enlarged English edition, with illustrations. In one handsome octavo volume of over 500 pages; cloth, $3 50.

This valuable treatise on diseases of the stomach and abdomen has been out of print for several years, and is therefore not so well known to the profession as it deserves to be. It will be found a cyclopædia of information, systematically arranged, on all diseases of the alimentary tract, from the mouth to the rectum. A fair proportion of each chapter is devoted to symptoms, pathology, and therapeutics. The present edition is fuller than former ones in many particulars, and has been thoroughly revised and amended by the author. Several new chapters have been added, bringing the work fully up to the times, and making it a volume of interest to the practitioner in every field of medicine and surgery. Perverted nutrition is in some form associated with all diseases we have to combat, and we need all the light that can be obtained on a subject so broad and general. Dr. Habershon's work is one that every practitioner should read and study for himself.—*N. Y. Med. Journ.*, April, 1879.

ELLIS'S DEMONSTRATIONS OF ANATOMY.

DEMONSTRATIONS OF ANATOMY; being a Guide to the Knowledge of the Human Body by Dissection. By **George Viner Ellis**, Emeritus Professor of Anatomy in University College, London. From the eighth and revised London edition. In one very handsome octavo volume of over 700 pages, with 256 illustrations; cloth, $4 25; leather, $5 25.

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CLINICAL LECTURES.

ON ASTIGMATISM AS A CAUSE FOR PERSISTENT HEADACHE AND OTHER NERVOUS SYMPTOMS.

A Clinical Lecture Delivered at the Hospital of the Jefferson Medical College.

BY WILLIAM THOMSON, M.D.,
Lecturer on Diseases of the Eye at the Jefferson Medical College.

GENTLEMEN: More than ten years ago I became aware that persons who consulted me for imperfect sight presented symptoms not fairly described in the various text books under the general head of asthenopia, and indicative of some serious disturbance of the nervous centres. These may be enumerated as pain over the brows, in the temple, occipital region of one or both sides, and vertex, with a sense of fullness, amounting to vertigo and nausea; mental depression and irritability of temper, inability to apply the mind, as in reading and writing; insomnia, loss of appetite, a fear of some impending apoplexy, or epilepsy, general nervous prostration, and, occasionally, choreic twitching of the muscles of the head and face. Finding these persons astigmatic, and seeing that their symptoms yielded to the supporting effect of properly selected cylindric glasses, the attention of Dr. S. W. Mitchell was called to this aspect of these sufferers, some of whom had been under his own care, and to him belongs the credit of calling the attention of the general profession to the subject in a paper in the *Medical and Surgical Reporter*, in 1874, and in the *American Journal of the Medical Sciences*, in 1876. Since these persons may be ignorant that they have defective eyes, they seek the advice of the general physician, rather than that of the ophthalmic surgeon, and to Dr. Mitchell's kindness I owe the opportunity of treating very many of these interesting cases to a successful conclusion; and a very large experience in private and hospital cases enables me to claim for such sufferers a careful examination, and the full correction of any optical defects that may be found, as indispensable to the relief of their many woes.

Published Monthly by HENRY C. LEA, Nos. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

☞ *In no case is this periodical sent unless the subscription is paid in advance.*

To describe astigmatism I must be pardoned a word as to the optical defects. The ideal eye, which may do all its work without our consciousness, must be a camera so formed that it receives on its retina the images of distant objects sharply defined; it must possess a perfectly curved cornea and crystalline lens, the distance from the apex of the cornea to the retina at the yellow spot, must be $\frac{9}{10}$ inch in length, and when these mechanical qualities are realized, sight for objects beyond twenty feet may be said to be automatic, and dependent upon sensation alone. Such an eye in viewing near objects must possess, however, the power of accommodation, and this is obtained by the grasping effect which the ciliary muscle can exert upon the elastic lens, under the power of volition transmitted through the third nerve. When two such eyes are used together, the third nerve of each side is used to excite contractions not only in the ciliary muscles, but also in the superior, internal, and inferior straight, and the inferior oblique muscles. Hence the eye possesses a power of prehension which must be vigorously used in obtaining accommodation and convergence when the person reads small print, or uses the eyes on other near small objects.

When a greater distance than $\frac{9}{10}$ in. exists between the front and back of the eye it becomes myopic, is not able to distinguish distinctly distant objects, and has too much power of refraction, which can be reduced by a concave or — glass placed before it. When the antero-posterior distance is less than $\frac{9}{10}$ in. it is called hypermetropic, and needs a convex or + glass for its correction; the glasses in each case indicating the degree of the optical defect. The perfect eye is called Emmetropic E, the other myopic M, or hypermetropic H.

In astigmatism these conditions may exist in various quantities, together, and the eye may see one part of an object and fail to see the other; it may see the vertical part of a letter **T**, for example, or the two sides of an O, and be unable to obtain perfect sight of the horizontal parts without some muscular effort, or change of distance.

A person who could see vertical lines with the E part of an eye at twenty feet distance, might have M for horizontal lines and would not see them until the eye had been carried by the organs of locomotion to a distance of twenty inches, when they would become distinct with the eye in repose, but the vertical lines would then need the prehensile power of accommodation to place them clearly on the retina, and a constant contraction and relaxation of these intricate muscular organs would be needed to secure good definition. Such an eye in repose could see such lines only when they were placed in perspective—the horizontal at 20 inches and the vertical at 20 feet, but when placed as letters are on the same piece of paper, they would yet for such an eye be apart, and the eyes would metaphorically labor in passing over a line of print as much as the legs would in walking over broken ground; and the same relief would come from a proper correction to such eyes by glasses as would follow a transition from a plowed field, or a road covered with large obstacles, to a hard level pathway.

Test glasses, which to obtain uniformity, are based on the metric system, are being gradually introduced and used by ophthalmic surgeons throughout the world, and are based upon a unit of 1 metre in the refractive power, and the glass No. 1 is a +, or convex glass, having a focal length or burning point of one metre, and is called a dioptric. The test cases contain these glasses ranging in power from .25 or $\frac{1}{4}$ of a dioptric = more than 13 feet focus, to 20 diop. or nearly 2 inches focus, and are spherical and cylindric in their curves, both convex and concave.

The power of the glass, and the degree of any optical defect may be easily comprehended if we regard the similarity between these dioptrics and our coinage, since the weak .25 is like our 25 cent-piece, and the glasses gradually increase until they are as strong as a twenty dollar-piece in glass of 20 D. The power of accommodation can be well understood in like manner, since we know that when an E eye looks at things at twenty feet and beyond it uses no accommodation, and if the person is young, say under twenty years of age, a page of print may be seen distinctly until it reaches a distance of four inches from the eye; and that the same effect can be produced by muscular pressure on the lens through the ciliary muscle that could otherwise be obtained by a + glass of 10 D, since a metre is = nearly 40 inches and 4″ is the $\frac{1}{10}$ of this quantity; hence when we read at any distance, say 10 inches, we know that we are using a power of 4 D on each eye to secure good definition. To this must be added the muscular strain which must also be exerted to converge and fix the eye balls by means of the third nerves acting upon the other above mentioned extra-ocular muscles. These explanations I hope will rob the clinical details of any reported cases of any difficulty, and will enable the reader to estimate the degrees of the defects which may have to be concealed or overcome by vigorous muscular contractions in getting clear vision of either far or near objects, since in all eyes of H type the sight for distant things is obtained by using accommodation, and thereforefore more than the usual strain must be also employed in such eyes for all near work.

It may be in brief assumed that the eyes must be either emmetropic naturally or must be rendered so by glasses, if we hope to get from them prolonged near use, since when such eyes are viewing distant objects they are in muscular repose, and see by the sensory part of the eye alone, and thus give the motor, muscular, and prehensile parts time to rest between their intervals of active use in grasping the objects that are to be clearly seen at a near point. Fatigue and pain then come greatly from an unintermitted use of the accommodation, and converging apparatus, in using eyes of imperfect construction; and if we can save that very unnecessary labour we give muscular repose, and apply to the jaded eye a mechanical treatment which common sense and the keenest physiological insight will both approve.

Case I.—Dr. F., age 34, struggled through his education with constant fatigue and headache, and consulted me in 1869, ten years ago; he had been corrected by a prominent ophthalmic surgeon, and was using

$$\begin{array}{l} \text{R} -1.5 \bigcirc -2\text{c.} \\ \text{L} -1.5\text{s} \end{array} \text{V} = 20 \left| \frac{\text{xxx}}{\text{cc.}} \right. \text{or } 1 \left| \frac{1\frac{1}{2}}{10} \right. .$$

No atropia had been used to paralyze his accommodation, and the astigmatism in the left had not been detected, whilst in the right, as will be seen by my result, he had overstated his optical defect, and had been much over-corrected, and indeed rendered by his glasses even hypermetropic. He saw well with only one eye, and suffered great fatigue in reading, for which he found even this poor correction better than the eyes alone. In reading he was obliged to place his page within ten inches without glasses.

A careful study of each eye revealed simple M in one meridian, and E in the other, and both eyes were brought up to full or perfect distant sight, viz., $\frac{20}{\text{xx}}$, by the following formula:—

R — 2.5c. axis 180°
L — 2c. " 165°

Serious changes in each choroid near the fovea and nerve entrance were also observed, and to arrest them and to afford relief from pain, he was directed to use his glasses constantly. Please observe the practical obstacles in this case in using the natural eye. This gentleman saw at twenty feet the vertical parts of test letters, the horizontal looking rubbed, as if the ink had been smeared over the paper when it was yet fresh, and this defect reduced his vision to $\frac{1}{10}$, *i. e.*, a letter could be distinguished only when it was ten times larger than it need be for the same eye corrected. When he placed his eye at a distance of 16 inches from a horizontal line, it only then became distinct, becoming blurred beyond. When two lines, one vertical and the other horizontal, were placed at 16 inches, or when he saw clearly both parts of a letter T or H, he was obliged to use for the vertical part an accommodative strain = a glass of 2.5 D, which might tire an eye as the lifting of 2½ lbs. would the arm. When this 2.5 of A had been secured by pressure upon the lens, the refraction for the horizontal line would be too great for perfect sight at 16 inches, and the distinct point for that line would optically be at about 8 inches; so that a distance of 8 inches would exist between the two parts of a rectangular letter. Finding it impossible to shift the position of two lines by movements of the hand or head, placing vertical ones at 16 inches, horizontal ones at 8 inches, he would endeavour to perform the same service by first contracting the ciliary muscle for the vertical, and using $A = 2.5$ D, and then relaxing it when the attention should be called to the horizontal line.

Imagine how tiresome such guarded careful adjustments would be with an opera glass made astigmatic purposely, and then consider that a person in reading must be ready to follow instantly any possible line which the printer or engraver may dictate, and you can perceive that to read with such an eye would be like endeavouring to see any details either on the surface of a tank of water, or at its depth of 8 inches, when the eye should be placed 8 inches from its surface, and directed downwards. Please remember also that when both eyes were converged and properly accommodated for 16 inches, that a new convergence would be needed for 8 inches, and you will get a mechanical idea of the muscular activity that would exist in a pair of such eyes, in following details of small type over the lines of a book, both third nerves directing not only the ciliary muscles, but also the whole group of extra-ocular muscles in exacting and guarded contractions and relaxations. No wonder that fatigue should follow, congestion, inflammation of the lids, and conjunctiva, nutritional changes in the fundus, and neuralgic pains over the frontal region, throughout the head, and even vertigo, and nausea.

For ten years these symptoms have been entirely removed by the glasses; no change has occurred; the V is the same; there is full power to use the eyes by day or night in near work; my patient performs all the duties of an active practitioner, and has enjoyed entire comfort. He cannot leave off his correcting glasses for five minutes without a return of pain, and a sense of fatigue. When his accommodation fails after 45 years of age, he may return for some further advice, and I will then order a + spherical on one side of his cylindrical correction for reading.

His cylindrical glasses are for his eyes simply what a cork jacket might be if he were thrown into the water; there would be no necessity for the severe muscular effort of swimming to keep his head above the surface, and he could float along in repose. I see this patient frequently, but have never heard him express but one opinion as to his eyes, that they are perfectly comfortable, and that all his old symptoms have long since disappeared—a result which he largely owes to his own professional knowledge and willingness to keep his glasses on his eyes properly whenever he is not asleep.

Case II.—Mr. C., age 36, first seen in 1870, has been under treatment for supposed disease of the brain and spinal cord by distinguished men here, in New York, and in several cities in Europe; has been in the hands of irregular practitioners of every school, but has never found any treatment of any avail. He states briefly that he is never well, except when leading an out-door life, shooting, fishing, etc., and that so soon as he returns to business his head symptoms return. He found by accidently using a — cylindric glass of a friend that he could see more sharply, and he consulted a distinguished ophthalmic surgeon, who, without having any other end in view, gave him — 2c on each eye, with which he has V nearly $\frac{20}{\text{XX}}$, but is not able to use the correction in reading or near use of the eyes. For over a year all his letters have been written by a secretary, by dictation, except his notes to his family, which he writes when absent with a dull lead pencil, in a large hand, and barely glancing at the paper. He is now under Dr. Mitchell's care, and consults me only to get a distant glass to enable him to shoot more accurately, thinking himself nearsighted. The least use of the eyes in his business, in examining anything which he takes in his hand, gives discomfort, so that he never exerts himself in that way more than a few minutes at a time; and as his headache from his oversensitive condition is increased by any excitement, emotion, or mental effort, he naturally ascribes his state to some serious disease of his brain. He states that after writing a few minutes he feels a creeping sensation extending along the spine from the shoulders to the back of the head; his hair seems to be rising up; he becomes giddy; severe pain ensues; his ideas become confused; he feels sure that he will have some "fit of some kind;" he throws down his pen, leaves his desk, goes into the open air, and in time these symptoms disappear. He has no faith when told that his suffering probably depends upon eye strain, but is willing to give every opportunity for a thorough examination.

His acuity of vision, $V = \begin{matrix} R & \frac{1}{3} \\ L & \frac{1}{3} \end{matrix}$, increased by the — cylinders he now has to nearly $\frac{1}{1}$, but I feel sure that he has not only a myopic astigmatism, but that there is also hypermetropia. This is concealed now by the use of accommodation, with which he corrects a H meridian, and hence overstates the degree of M. The accommodation was paralyzed by atropia, and his entire ametropia, or optical defect, corrected by a convex or + spherical glass combined by a concave or — cylindrical, to overcome the astigmatism.

The following formula gave him $V = \frac{20}{XV}$, or above the average amount, viz.,

$$\begin{matrix} R + 1 \bigcirc - 3c. \\ L + 1 \bigcirc - 3c. \end{matrix} \quad \text{Axis } 180^\circ\text{, or horizontal.}$$

These glasses gave clear, exact definition upon his retina of objects at and beyond twenty feet, and his brain received all its impressions through the sense of touch alone, whilst before using atropia to paralyze the ciliary muscle, the motor or prehensile muscular apparatus was compelled to co-operate incessantly, and fatigue necessarily ensued. These glasses he was directed to wear constantly. When his eyes recovered from atropia, he saw accurately with eyes in repose for distance, and could use A enough to read at 6 inches from the eye. All his nervous symptoms at once disappeared, and he has been free from them for years, except when by the usual mischances he gets his glasses improperly ground, or placed before the eyes.

It needed only one experiment to test the value of the correction in his case, and that I was of course unwilling to try, viz., to leave off, or impair by intention the fulness of his correction. This was done, however, by accident, in the following way:—

Recently, after nine years of comfort, he arrived at the period when old sight comes to us all, at about forty-five years of age, and finding himself labouring in reading at night with his far correction, I prescribed a formula which would give an ordinary pair of old glasses with the astigmatic ones. I gave $+ 2 \bigcirc -3c.$ ax. 180° on each eye. This formula he took to Paris, and ordered from a celebrated maker a pair to be constructed of pebble instead of glass. The optician, thinking he could grind the lenses more conveniently than by following explicitly my formula, undertook to arrange the quantities differently, and ground other curves than those ordered on each side of his glasses. Mr. C. brought them home, placed them on his eyes, and endeavoured to use them in writing, when, although he saw clearly with them, his old symptoms of congestion returned so severely, time after time, that he was compelled to hold his head under a cold water douche to obtain relief. He then consulted me very recently, the error was discovered, that the glasses yet left him with a part of his astigmatism not corrected; a second pair were made from the proper formula, and again all his fatigue and headache disappeared. No better testimony could be needed than this experiment which chance provided for us, to satisfy us that his nervous symptoms had not been removed by any effort of nature or natural improvement in eyes or brain, but that they had been averted for years by an ingenious mechanical support applied to a defective organization.

Case 3.—Dr. G. M. S., age 39. "Was a medical officer in the navy, and in 1866, after exposure to malaria, he suffered from pain at the base of the brain, singing in left ear, mental restlessness, inability to apply his mind, pain over left brow extending to back of head, with a feeling of severe tension; was then reading a good deal, but after twenty minutes he could not keep his attention fixed, and thought this a failure of mental vigour." He left the navy on this account, after failing to get relief, through the advice of several distinguished men, and went to Minnesota and spent a year in open-air life, avoiding all books and newspapers. He then felt relieved, returned to work in civil practice, avoiding much reading, but in 1868 his symptoms returned, with much anxiety as to his power to sustain himself. His general health seemed good enough, he was an athlete, and could lift one thousand pounds, but was convinced that he laboured under some form of disease of the brain. Without any change he remained until 1872, when his case was diagnosticated by a great authority in disease of the nervous system, as cerebral congestion, and was treated by the latest novelties in therapeutics. Taking some interest in eye diseases, whilst under treatment for some months in New York, he was given glasses which improved his distant sight, but no thorough examination was made. In 1875 he spent some time in Colorado, to escape work and live in the open air. The light gave him much distress, and there were developed the signs of nervous headaches or megraine, marked by the coloured subjective flashes of light in the eyes, arranged in zig-zag lines, lasting half an hour, followed by severe hemicrania, loss of sight in the half of each visual field, and nausea. During the past year he has had probably twelve such attacks. Upon consulting Dr. Mitchell, he referred him to me, hoping that some form of optical defect might be found to account for a part of his sufferings in Oct. 1878. His general appearance, and the fact that his symptoms have continued now since 1866, render any severe cerebral disease improbable. He can read for thirty minutes, but feels the strain after one minute; is compelled to desist by headache, which would culminate in nausea. $V = {R \atop L} 20$ $\frac{\text{L}}{\text{XL}} = 1\Big|\frac{2\frac{1}{2}}{2}$, with atropia and paralyzed accommodation, $V =$ only $\frac{20}{\text{CC}} = \frac{1}{10}$, and this is the only visual power he possesses without strain. The result of the examination was to develop here, as in the preceding case, a combination of H and M, which the formula will explain—

R + 2. ○ — 3c. ax., 170° $V = \frac{1}{1}$,
L + 1.75 ○ — 2.5c. " 5° $V = \frac{1}{1}$.

So that, without any muscular effort on his part, his sight was increased tenfold by the correction, or from $\frac{20}{\text{CC}}$ to $\frac{20}{\text{XX}}$.

In December last he writes that, with the glasses, "I can now engage my eyes in constant work for half a day at a time, without the distressing hemicrania and fatigue which was certainly consequent upon such effort, continued not over one hour. The glasses are an inestimable boon," etc. He also states that he has had but one attack of nervous sick headache, and that not so violent as on former occasions.

This gentleman was corrected under great pressure for time, and would be benefited by some further advice, but I feel sure that most of his fancied cerebral symptoms have entirely disappeared, and that his nervous headaches will be lessened in number and severity, although it must be remembered that this form of headache is probably inherited, and will prove as intractable to the use of glasses as it has hitherto done to skilful medication. So satisfied was Dr. Mitchell as to the cause of the distress in this case, that he gave no treatment beyond advising him to follow closely the instructions which were given as to the use of his correction.

On May 19 a letter, introducing a patient who suffers from eye-strain, contains the last report from Dr. S. He says: "My cylindrical lenses have lightened and rendered comparatively painless many hours of labour since using them."

In contrast with these very marked cases of nervous trouble and defective sight, I will give, as interesting, from its insidious character—

Case 4.—Mrs. W., age 44, Nov. 11th, 1874. For three years past prolonged sewing would cause a sick headache; has almost given up the near use of eyes in sewing or reading in consequence, $V = \substack{R \\ L}\ 20\,\frac{\text{XX}}{\text{XXX}}$; slight chronic conjunctivitis. Finding that she could not see within 12 inches, and would accept + glasses, I prescribed spherical glasses of 1.25 D, and astringent lotion for the hyperæmia.

Dec. 20. Has used the glasses nearly constantly, reads longer, but yet has pain throughout the entire head, particularly in the occipital region.

Jan. 12. No improvement. The spherical glasses fail to give relief.

Jan. 19. Use atropia, which reveals simple H. Vision with no glass $= \frac{20}{\text{LXX}}$ restored by + 1.25 to $\frac{20}{\text{XX}}$ Right. For Left find H and A; under atropia $V\,\frac{20}{\text{LXXX}}$; corrected to $\frac{20}{\text{XX}}$ by + .75s. ⊂ + 1c. ax. 80°.

R + 1.25s. V $\frac{1}{1}$.
L + .75 ⊂ + 1c. ax. 80 V $\frac{1}{1}$.

May 6. Has used glasses constantly, and is entirely relieved of the dragging pain in back of neck and head; has been able to sew longer than for years. No further treatment.

Dec. 1876. Returns with statement, that has had headache day and night for some weeks, located in each eyeball, over the brows, and in the nape of neck. She has lost her appetite; there is general nervous prostration; she sleeps badly, and is so irritable and sensitive as to render any examination very difficult.

Alarmed and disappointed at this return of her pain, in spite of careful correction, I was wondering what next to do, when, glancing through her correction held in my hand, I perceived that the glasses had been changed—the R., which was a plain S., being now in the left side of the spectacle frame, and over the astigmatic eye, which it could not correct; and the sphero-cylinder belonging to the Lt. being now placed over the Rt., which was not naturally astigmatic, but is now rendered so by the accident. In fact, the patient now suffers from two astigmatic eyes instead of one. She knew of no change, and insisted that the glasses had not been tampered with; but on closely questioning her, she remembered that in the summer the frames had been broken, had been sent to be repaired, and no precautions had been taken to call attention to their cylindrical character; hence, the person who repaired the frames had, by accident, furnished us with the very best evidence of the value of the correction, since, when the work of the autumn had been resumed, after a summer of rest, our patient using the glasses with full confidence, and having both eyes injured and not benefited by them, had all her old symptoms reproduced, and in greater violence. This having been explained, she had the glasses properly placed, and was again entirely relieved, and dismissed from observation in Jan. 1877. Since then I have been obliged to correct the old sight, but there has never been any headache from eye-strain. Twice she has had curious attacks of megraine, with intense subjective sensations of lights flashing continuously in each eye lasting for three hours, and culminating in sick headache, from drinking lemonade.

Case V.—Within a few days a young girl, Miss M., was brought to me by her mother, age about 40, and accompanied by her grandmother, over 70 years of age. For the past three winters this young girl had commenced school, but in a few weeks had been obliged to give up her studies, on account of severe pain which was felt in the back part of the left eye, attended by twitching of the muscles. Finding her sight nearly perfect, and observing no sign of disease on inspection of the eyes, I suspected astigmatism, and knowing how often this defect is transmitted by inheritance, I asked her mother, a delicate, pale, feeble-looking woman, if she suffered from headache; she responded that she had done so for years—but that it was neuralgic—had never been relieved by any treatment, but that it was congenital, as her mother had suffered in the same manner. This statement was confirmed by the grandmother, and I added that she had now been free from pain for some years, to which she acquiesced. I then predicted that all three would be found to be astigmatic, and that the absence of pain in the grandmother was due to the fact that her accommodation had become so deficient from age that she could no longer force her eyes to render her sight sharp; the mother was informed that she would probably outgrow her neuralgic pain, but that it would now yield to proper glasses, and that the young girl would do no more serious work at school until her defect had been corrected. An examination was then quickly made, and these predictions were verified so far as the presence of astigmatism was concerned. The grandmother presented two such eyes, the mother was also astigmatic, and the young girl had her painful eye in a like condition. This is not surprising when we remember that astigmatism is generally caused by a slight malformation of the cornea, which consists in having its meridians of curvature irregular in length of radius, and that this peculiarity of formation might, and is frequently transmitted by inheritance, as readily as would any other physical peculiarity of structure. These cases have not been critically examined, and hence no details can yet be given.

I regret that in the space of a clinical lecture, and under the necessity of presenting the ideas conveyed in a rapid or rather informal manner, I can do no better justice to what seems to be an important and too little known advance in the treatment of cases presenting symptoms that might easily be confounded with those of serious disease of the nervous centres. Hundreds of cases, all more or less differing in the clinical details, have passed under my notice, and are recorded in my note books; and nothing but a full and candid investigation of each case will suffice to answer the objections that might be made to the views now presented. The asthenopia of hypermetropia is well described; also the fatigue and discomfort often attendant upon myopia, with its complication of insufficiency of the internal straight muscles, but the train of evils enumerated above belong especially to astigmatism, and will be found in those who endeavour to use such defective eyes in prolonged near work. When people with marked astigmatic refraction are found who have not suffered from eye strains and pains in the head, etc., it will generally be found that they have little inclination or necessity for prolonged near use of the eyes, since it seems that the symptoms are dependent upon that constrained and incessant use of the complicated muscular apparatus concerned in the accommodation, convergence, and proper binocular use of such defective organs. No success can be expected in correcting such eyes without the full use of atropia, or better duboisia, which will entirely paralyze the accommodation, and eliminate all power which the patient might have in concealing his defect; and finally great perseverance and great faith must be exercised by the patient in the constant use of the glasses, if the eyes are to be compared in comfort and working power with those of an emmetropic type. The most rapid test for the general practitioner to use to detect astigmatism is a small point of light, either a circular opening in an opaque screen, or a gas light turned down to a small yellow point, which must be regarded by the patient at not less than sixteen feet distant. Emmetropic eyes see this light as a small point, whilst to astigmatics it is distorted into a streak, of greater or less extent, which will change its direction as the patient rotates his head from a vertical to a horizontal direction. When myopia, or high degrees of hypermetropia are mingled with astigmatism, the light point may appear to be not a circular disk of light but an ellipse. The case then surely needs the prolonged and patient study requisite for its correction as the most rapid and safe means of treatment.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Proceedings of the American Medical Association.

(Specially reported for the MEDICAL NEWS.)

The thirtieth annual meeting of the American Medical Association was convened at Atlanta, Georgia, on Tuesday, May 6th, 1879, Dr. Theophilus Parvin, of Indianapolis, President of the Association, presiding. Three hundred and fifty delegates were registered. The session was marked by an unusual amount of good feeling, sociability, and harmony. The old question about the Arkansas State societies reappeared; it was settled, it is to be hoped, permanently, by the Judicial Council deciding to recognize the delegation from the one known as the Arkansas State Association. The contemporaneous meeting of the National Board of Health in Atlanta gave the Association the benefit of the presence of a number of leading sanitarians, and procured for discussions on State medicine a prominent position in the proceedings.

General sessions for business were held each morning, when, besides the routine work, the chairmen of the different Sections in rotation each presented an address embodying the progress in his special department during the preceding year. In the afternoon the meeting was divided up into Sections, which were constituted as follows:—

Section I. *Practical Medicine, Materia Medica, and Physiology.*—Chairman, Dr. Thos. F. Rochester, of Buffalo, N. Y.

Section II. *Obstetrics and Diseases of Women and Children.* — Chairman, Dr. E. S. Lewis, of New Orleans.

Section III. *Surgery and Anatomy.*— Chairman, Dr. Moses Gunn, of Chicago.

Section IV. *State Medicine, Public Hygiene, and Medical Jurisprudence.*—Chairman, Dr. J. S. Billings, of Washington.

Section V. was consolidated with the preceding by resolution adopted at this meeting.

Section VI. *Ophthalmology, Otology, and Laryngology.* — Chairman, Dr. Hermann Knapp, of New York.

For scientific value, the discussions in the last Section, under the charge of Dr. Knapp, probably took the lead; those in the Section on State Medicine coming next; while those on Practical Medicine were decidedly below the average, and the Section was poorly attended. The Sections on Surgery and on Obstetrics had the largest numbers in attendance; but much better results could be obtained, and less time lost in reading unimportant essays, if all papers were submitted for examination to a committee of experts belonging to the Section, before being read as part of the proceedings.

General Sessions. — The meeting was called to order on Tuesday, May 6th, by the President of the Association.

The Address of Welcome was made by Dr. Logan, Chairman of Committee of Arrangements, and was followed by the Presidential Address, which was received with the closest attention and hearty applause. It was replete with thought, and revealed close attention on the part of the writer to the current literature of natural science.

Dr. E. Seguin offered resolutions in regard to the use of the metric system, which were subsequently adopted, declaring that the Association formally adopts the system, and will require, in future, its employment in all communications, and recommending its general use.

Second Day.—On the second morning a resolution was passed, though not without opposition, requesting Congress to remove the high tariff on quinia.

The Judicial Council having reported as a special committee an amendment condemning, as opposed to the code of ethics, the practice of instructing students who intend to practise an irregular or exclusive system of medicine, which was laid on the table.

Third Day. — Dr. N. S. Davis read a brief but pointed address on Ozone, which was referred for publication. Dr. J. M. Toner presented the report on Necrology, and H. C. Wood a report on the National Library, which were both received and ordered to be printed. Reports were also received from the Publication Committee, the Treasurer, and the Librarian. The Committee on Nominations reported as follows:—

President. — Lewis A. Sayre, M.D., of New York.

Vice-Presidents.—*1st.* R. Beverly Cole, M.D., of California; *2d.* E. M. Hunt, M.D., of New Orleans; *3d.* H. O. Marcy, M.D., of Massachusetts; *4th.* F. Peyre Porcher, M.D., of South Carolina.

Treasurer.—R. J. Dunglison, M.D., of Pennsylvania.

Librarian.—Wm. Lee, M.D., District of Columbia.

Committee on Library.—Johnson Eliot, M.D., District of Columbia.

Asst. Secretary.—Walter Gillette, M.D., of New York.

Next place of meeting, New York.

Time of meeting, First Tuesday in June, 1880.

Committee on Arrangements.—Drs. L. O. Vanderpoel, Stephen Smith, Wm. M. Polk, Robt. Weir, Chas. I. Pardee, A. A. Smith, T. F. Sabine, of New York; Jos. C. Hutchison, of Brooklyn; M. H. Burton, of Troy; and Dr. Parker, of Poughkeepsie.

Committee on Prize Essays.—Dr. Austin Flint, Chairman; Drs. Alfred C. Post, Jos. C. Hutchison, J. W. S. Gouley, and Montrose A. Pallen.

Committee on Publication.—Drs. W. B. Atkinson, T. M. Drysdale, A. Frické, S. D. Gross, Caspar Wister, R. J. Dunglison, all of Pennsylvania; and Wm. Lee, of District of Columbia.

The following are the nominees for officers of Sections for the next meeting:—

Section I.—Dr. J. S. Lynch, of Maryland, Chairman; Dr. W. C. Glasgow, of Missouri, Secretary.

Section II. — Dr. Albert H. Smith, of Pennsylvania, Chairman; Dr. Robert Battey, of Georgia, Secretary.

III. Dr. W. G. Briggs, of Tennessee, Chairman; J. Powell Adams, of Minnesota, Secretary.

Section IV. Dr. J. F. Hibbard, of Indiana, Chairman; Dr. T. E. Wood, of North Carolina, Secretary.

Section V. Dr. Bolling A. Pope, of Louisiana, Chairman; Dr. Eugene Smith, of Michigan, Secretary.

Committee on Necrology. — Dr. J. M. Toner, of District of Columbia, Chairman.

Dr. Brodie presented a communication from the Association of American Medical Editors, declaring it to be a violation of the spirit of the code of ethics for editors to advertise patent medicines, which was referred to the Judicial Council.

Dr. N. S. Davis, of Chicago, made a report from a special committee on questions discussed by President T. G. Richardson in his annual address of last year. It favoured amendment of the present rules on prize essays, and recommended the expunging from section 3 of all relating to prize essays, and the insertion of a clause declaring that there shall be four prizes of $250 for the best original contributions to medical knowledge. The chairmen of the sections on Practical Medicine, on Obstetrics, and Surgery and Anatomy, on State Medicine, shall take charge of the competition and arrange its methods. The report to lie over for action until next year under the rule. It was received and the committee discharged.

The Committee on Prize Essays awarded the prize to Allan McLane Hamilton, M.D., of New York, for a paper entitled "A Consideration of Certain Forms of Primary and Secondary (local) Degeneration of the Lateral Columns of the Spinal Cord, with Special Reference to an Infantile Rare Form."

Papers and Discussions in the Sections.—The addresses of the chairmen, which were referred to the sections for discussion, were practical and unusually valuable. Dr. Rochester, of Buffalo, in connection with epidemic zymotic diseases, urged the establishment of a system of national quarantine, which, though vigorously opposed by a minority, was sustained by the sentiment of the Section on Practical Medicine. Dr. Lewis, of New Orleans, Chairman of the Section on Obstetrics, gave an admirable summary of progress in his branch, and the application of antiseptics to gynæcology; he recommended extirpation of the uterus in cancer, removal of ovaries in Cæsarian section, and ergotine injections in uterine fibroids. The Surgical Section approved of the views expressed by their chairman, Dr. Moses Gunn, of Chicago, on the value of antiseptic system, and the vital origin of pus. Dr. Chaillé, in his annual address, appealed for the establishment of a sound system of State Medicine, in which the general government should regulate without necessarily interfering with any necessary powers of the State. He argued that it lay in the power of the American Medical Association to effect the reforms needed in the present condition of State medicine. In England State medicine is easily and judiciously regulated by the influence of the British Medical Association on one central legislative power, while in America this power must be frittered away on the local legislatures of forty-eight States and Territories.

The address of Dr. H. Knapp, on the Progress of Ophthalmology, Otology, and Laryngology, was full of detail, but very interesting.

A number of papers, generally of practical character, were read in the different Sections.

The entertainments included a grand banquet, a number of receptions, and an excursion to Augusta, all of which appeared to be thoroughly enjoyed by the guests of Atlanta and her hospitable citizens.

—

The National Board of Health. Meeting at Atlanta, Georgia.—An important session of this Board was held in Atlanta, commencing May 5, 1879, when it met by invitation a number of leading sanitarians from various parts of the country, including the members of the Sanitary Council of the Mississippi Valley.

The question of maritime quarantine being announced as the order of business for the first day, Dr. Vanderpoel, of New York, in an able address, opened the discussion, in which Drs. Cleemann, of Philadelphia, Howard, of Baltimore, Bemiss, of New Orleans, Greenville Dowell, of Texas, and others, participated.

Dr. Vanderpoel said that there never was a space of three days in the summer when there was not yellow fever in the port of New York, and yet it was kept out of the city by a thorough quarantine.

Dr. Chanceller, of Baltimore, read a paper opposing the opinion that quarantine is effective against yellow fever. The general sentiment of the meeting, however, was in favour of careful inspection of vessels arriving from infected ports, thorough fumigation and strict quarantine. The opinion was also expressed that quarantine should be continued throughout the year in Southern ports, or at least a much longer time than is needed at the North.

The second and third days of the session were devoted to the questions of river transportation; (*a*) how to secure for a steamer freedom from infection at New Orleans; and (*b*) how to deal with steamers at ports along the Mississippi and its tributaries; submitted by the Sanitary Council of the Mississippi Valley.

Dr. White, of New Orleans, stated that the only way he saw of preventing the infection of a vessel in the port of New Orleans was to prevent it from coming alongside an infected vessel. The law of Louisiana provides that an infected ship shall be at once removed from port to the quarantine station; so that ships rarely become infected from contact with infected ships in port. A ship that had been infected should be thoroughly cleaned, and the hold white-washed before she was allowed to go up the Mississippi.

Mr. Eicklehart, of Vicksburg, thought that an infected vessel should be sunk just below the hull for disinfection.

Dr. Chaillé, of New Orleans, remarked that if we accept the general belief that textile fabrics are a source of great danger in transmitting the fever, the great question is not what should be done with the hull of a vessel, but what measures should be taken that these materials shall not be transported to ports above?

Dr. Mitchell, of Tennessee, said that the only resource Tennessee had against the fever was to establish a total non-intercourse with infected ports; 99-100ths of the people believe in quarantine. It is humiliating to admit that this is the only preventive. A subject of great importance is to find means by which communication can be kept up with an infected port. Of all vessels of river navigation he looked upon the barge as one of the greatest sources of danger—on account of the usual nature of their cargoes, their peculiar construction, and their poor ventilation. In 1873, Memphis was infected from a barge, and doubtless again in the same manner last year. River commerce needs protection from this source of infection. Mr. Mitchell also advocated the feasibility of a system of stations of inspection to be located along the Mississippi—so that it could be ascertained if a vessel became infected between ports. He was satisfied that total non-intercourse provided protection against infection, but that this preventive is an extreme one, and in itself undesirable.

Mr. Nash, of Norfolk, stated that during the epidemic in Richmond and Lynchburg, Norfolk kept up continual intercourse with these cities by transferring freight at Hampton Roads. He thought the same system might be practicable on the Mississippi River.

Dr. Rauch, of Illinois, supported the theory that the treatment of inland commerce should be analogous to that of foreign commerce; the prevention of the introduction of infectious diseases should be equally the object in both. Under ordinary circumstances a steamer should be examined at New Orleans before being allowed to go up the river; and in times of an epidemic, extra precautions should be taken. Stations should be located along the Mississippi for the care of the sick, and for the disinfection of vessels. The way passengers and crews are treated in time of an epidemic is barbarous. If the captain cannot land them in cities he lands them in swamps or anywhere along the river. Humanity demands a system of inland prevention as well as a foreign quarantine.

Dr. Pinckney Thompson, of Kentucky, stated that to his mind it was clear that yellow fever can be carried from place to place in textile fabrics, and the only thing to be done by up-river towns when fever is in New Orleans, is to prevent steamers from landing. There are but two resources remaining for these towns. One, to keep themselves in such a sanitary condition as to render the introduction of the yellow fever harmless; the other to insist that New Orleans keeps the yellow fever from her port just as New York does. When the fever is not in New Orleans, the towns along the river are always safe.

Dr. A. N. Bell, of New York, cited experiments that he had made in heat disinfection. He stated that thirty-one years ago he was called upon to take measures against the yellow fever on a schooner that came from a point where the disease had been raging two years. For three hours he steamed the ship under as intense heat as the boilers would give; then he thoroughly scraped and painted the vessel. A year later the ship went on a cruise in the worst fever ports of the West Indies, and no case of fever was developed on board. At the same time and place he treated a gunboat in the same manner, with the same results.

Some time later two boats were taken from the same squadron to New York, passed quarantine, but, though no cases of fever had been aboard for some months, the men engaged in remodelling them in a New York dock, were infected with the fever. These boats had not been disinfected by the steam process. Other experiments in steam disinfection which Dr. Bell has since made in person were cited, and though there have been some failures he attributes them to a lack of thoroughness in the process. Steam heat is preferable to dry heat, because the former can be used with less damage to goods.

In speaking of disinfectants, Dr. Bell denounced the idea that slaked lime is of any use, the quick-lime only is of value.

The next subject of discussion was the second memorandum from the Sanitary Council, on inland quarantine:—

Railroad—(*a*) Sanitary condition of depots and stations. (*b*) Quarantine stations on railroads, their position and organization; specify for passenger trains, sleeping cars, car construction, freight trains, construction trains. (*c*) Mails. (*d*) Expressage.

Dr. Kedzie offered the following:

Resolved, That the depots and stations of railroads and their surroundings should be kept in a sanitary condition, free from all stagnant water and decomposing organic matter; the local railroad agent or official should daily inspect the water closets, and cause the floor, seats and urinals of such water closets to be kept clean; the vaults to be emptied at least every three months, and from the 1st of May to the 1st of November, the privy vaults to be disinfected every week, by pouring into every vault a solution of twenty to fifty pounds of sulphate of iron or sulphate of zinc, or ten to fifteen pounds of chloride of lime.

This resolution was approved.

Dr. Kedzie said that fever often germinated in the North from causes that the resolution does away with. Germs of disease from decomposition often are carried in the air to a distance. Cholera may be propagated in the same way.

Dr. Howard spoke of the relation of railway travel to the yellow fever question. On his way to the fever district last summer, he entered a sleeper, in company with other persons, in which he was positively assured there had been no fever. Soon afterwards he learned that there had been dozens of cases aboard the car. When they arrived in Mississippi a man in the car was attacked with the fever. They bundled him up in the fever-infected blankets of the car, and put him in a fever-infected berth. The engineer was soon attacked and treated in the same way. Soon afterwards a lady in the car showed unmistakable symptoms of the disease; she also was cared for in the same manner. This car, at its destination, was immediately sent back on a trip to Cincinnati. The doctor cited other instances of similar scenes from his own experience.

Dr. Kedzie here offered resolutions upon the ventilation of cars, as follows:—

"All railroad cars should at all times be well ventilated; the freight cars when loaded should have barred doors to permit the free entrance of air at all times whether moving on the track or placed upon the sidings; the passenger and sleeping cars should be provided with automatic ventilators, so as to secure a rapid change of air in the cars at all times.

"The upholstering of all passenger and sleeping cars, including the cushions of seats and mattresses and sleepers, shall at least twice a week, and in the open air, as far as possible, be thoroughly whipped and brushed, and the blankets and curtains of sleepers shall be whipped and sunned thrice weekly.

"In case of infection of a car or sleeper, the bedding, mattresses, and all the upholstering shall be thoroughly disinfected before it is permitted to be again used."

In regard to the final queries as to what should be the system of notification of the occurrence of the first cases of a dangerous disease, and when it is proper to say that yellow fever is epidemic in a town, it was decided that these queries had been already discussed and answered by State and local authorities.

The final session of the National Board of Health was held at the Kimball House on Thursday, May 9th, President Cabell in the chair.

Dr. Rauch, Secretary of the Sanitary Council of the Mississippi Valley, requested, before the regular routine of business was entered upon, to be permitted to report to the Board a series of propositions which had been adopted by the Sanitary Council on the preceding evening. The propositions were read and left with the National Board of Health for future consideration. A plan—the arrangement of which had sometime ago been referred to a committee—was then adopted, securing co-operation between the National Board of Health, the Sanitary Council of the Mississippi Valley and the American Public Health Association, in collating knowledge of the actual sanitary condition of every city in the United States, particularly in the Southwestern States along the Mississippi River. It is designed to ascertain as far as possible everything that will tend to affect the sanitary condition, whether for good or evil, of the various cities—the systems of sewerage, the condition of vaults, and the disposition that is made of refuse matter, and from these data to compile the best sanitary regulations, and correct existing abuses.

After adopting these measures the National Board of Health agreed to meet in convention at Nashville on the 8th of November. From this it is not to be understood that the National Board of Health has literally adjourned until that date; they will, on the other hand, hold session during the entire summer. The report of the debates and proceedings at this the Atlanta convention, together with the proposition reported to the Board by the Sanitary Council, will be thoroughly discussed. From these discussions will be ascertained, as far as possible, the best sanitary measures for the prevention as well as the eradication of epidemics; these results when obtained will be furnished to local and State sanitary bodies. Then the Board will meet in Nashville, there to hold a conference similar to the one just held in Atlanta, with leading sanitarians invited from every quarter of the union. Should the Board obtain an appropriation of six hundred and fifty thousand dollars from Congress, as they desire, they will be enabled themselves to put into effect the results of their deliberations; but with their present means they can only accumulate knowledge, deduce sanitary measures from it, and refer them to local and State authorities to be put into effect.

The Sanitary Council of the Mississippi Valley and the American Health Association have also agreed to meet in Nashville on the 8th of November.

—

The Convention of American Medical Colleges.—The advocates of reform in medical education, at the last meeting of the American Medical College Association succeeded in passing a resolution calling for a general convention of American medical colleges, in order to have an opportunity of obtaining the opinions of colleges not members of this association, in regard to the practicability of elevation of the standard of requirements for graduation. In conformity with this, a call was issued for representatives from each board of trustees, as well as every accredited college faculty, to meet in convention in Atlanta, May 1st, 1879.

By creating a commission with power to act, it was hoped that some decisive measures would be adopted that would be of great influence in advancing the standard of medical instruction, and making it more thorough and complete.

Prof. Gross was called to the chair, when the committee on credentials announced that only 24 out of 59 colleges were represented.

After discussion, a committee was appointed, which presented two propositions for the consideration of the convention:—

First. That all medical colleges should require attendance upon three regular courses of lectures during three separate years, before admitting students to become candidates for the degree of M.D.

Second. That the medical colleges should require, before admitting to matriculation, a preliminary examination, such examination to embrace, at least, the elements of the physical sciences in addition to a fair English education.

These propositions were adopted and ordered to be transmitted to the meeting of the American Medical College Association the next day. The convention then adjourned *sine die.*

—

The Association of American Medical Colleges.—The third annual session of this association was held in Atlanta, May 3d, 1879.

Dr. N. S. Davis announced the death of the President of the association, Dr. John B. Biddle, of Jefferson Medical College, and spoke in fitting terms of the loss the association, the profession, and the community had sustained in the death of this distinguished physician.

Resolutions expressing the sentiments of the association were subsequently adopted.

The following amendment to the by-laws was adopted: "Every college member and every affiliated college shall print each year a true list of matriculants of the college for the year, and their preceptors, or the names of the colleges at which the matriculants have graduated (in the cases of those matriculants who are graduates), and every such college shall also print a true list of the graduates for the year."

It was stated that the object of this section is to provide that every member of the association shall have means of information with regard to the matriculants, their preceptors, and the graduates of each college.

The charges against the Louisville Medical College were dismissed, as being defective in form, and, moreover, the course at this school had been changed so as to obviate any objection.

The Committee on Registration announced that the fifty-nine regular medical colleges in the United States graduated in 1878, 2708 students. Twenty-eight colleges are members of this association.

The Secretary announced the voluntary withdrawal of Dartmouth College, because it could not lengthen its term.

A resolution, that gratuitous instruction to medical students by any member of the association, except as provided by law, be declared unlawful, was adopted.

The communication containing the propositions from the Convention of Medical Colleges was read, and was laid over for one year. The following amendment was also laid over: "Resolved, That the majority of the members of one faculty shall not constitute the majority of the members of another faculty, unless the sessions of the two schools are held simultaneously."

Professor Chaillé called from the table the following: "Resolved, That it shall be considered derogatory to the dignity and good standing of any medical college represented in this association, to advertise, in any other than a strictly medical publication, the names of its professors, with their respective chairs."

(This does not apply to the annual circulars and catalogues issued by the colleges, but to advertising in newspapers and other like publications, in which only a card calling attention to the advantages of the school, length of session, fees, etc., with the name of the executive officer or secretary appended, should be permitted.)

After full discussion, the resolution was adopted.

Professor Chaillé also offered the following amendment to the articles of confederation: "No college shall advertise in any other than a strictly medical publication the names of its professors, with their respective chairs."

The amendment was seconded, and laid on the table till next year.

Prof. S. D. Gross was elected President of the Association; Prof. N. S. Davis, Vice-President; and Prof. Leartus Connor, Secretary aud Treasurer.

Place of meeting, in 1880, New York; time, the Friday before the meeting of the American Medical Association.

The Association of American Medical Editors.—On the evening before the meeting of the American Medical Association, this body held its eleventh annual session. Dr. Brodie presented a resolution condemning the advertising of patent medicines by medical journals, as opposed to the spirit of the code of ethics. An amendment to the constitution, admitting authors to membership, was laid over until next session. Dr. Parvin announced the death of Dr. Isaac Hays, and paid a warm tribute to his industry and ability. He also reported the death of Dr. Waddell, and asked that a committee be appointed to frame appropriate resolutions, which was unanimously adopted.

The following officers were chosen for the ensuing year: for President, Dr. Thomas S. Powell (Atlanta), of the *Southern Medical Record;* for Vice-President, Dr. Frank Woodbury (Philadelphia), of the *Boston Med. and Surg. Journal;* Secretary and Treasurer, Dr. Frank H. Davis, of Chicago. Next place of meeting New York, on the evening before the first Tuesday in June, 1880. A dinner was given to the Association on May 7th. by the editors of the *Southern Medical Record*, at which nearly all of the editors were present.

Medical College of Ohio.—Dr. Roberts Bartholow, in consequence of his intended removal to Philadelphia, has resigned the chair of Theory and Practice of Medicine in this institution, and Dr. James T. Whittaker has been elected to the vacant professorship.

Chicago Medical College.—Prof. Edward W. Jenks, of the Detroit Medical College, has accepted the chair of Gynæcology, in the Chicago Medical College, and will shortly remove to Chicago.

University of Maryland.—Dr. I. Edmondson Atkinson, of Baltimore, has recently been elected Clinical Professor of Dermatology in the University of Maryland.

9b

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CLINICAL LECTURES.

ON FRACTURES OF THE SKULL.

A Clinical Lecture Delivered at the Pennsylvania Hospital.

By WILLIAM HUNT, M.D.,
Surgeon to the Pennsylvania Hospital.

GENTLEMEN: An unusual number of injuries of the head have been admitted into the hospital during this term. In my wards alone, seven cases of serious fractures of the skull, six of them compound ones, have been treated during the past three months. I will present a short account of them first, and afterwards make my comments.

CASE 1.—J. D. M., aged 40, admitted March 2, 1879, was struck by a glass pitcher over the superior and lateral part of the left occipital region. There was an extensive and ragged scalp wound, at the bottom of which was a slightly depressed fracture. There was bleeding from the left ear. The patient was sensible, and did not exhibit any signs of paralysis. In the sitting posture he had constant nausea and slight vomiting. There was some stupor, but he could be easily aroused. The recumbent position, cold compresses, and low diet were ordered. The bleeding from the ear was followed in a few days by the flow of a clear fluid, and there was absolute deafness on the same side. The diagnosis was that the fracture extended, in the shape of a fissure, through the petrous portion of the temporal bone to the base

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of the skull. The wound healed kindly; but it was some weeks before the patient could sit up with any degree of comfort, as he complained of dizziness, and that his head was too big on one side. He also had noises in the ear. On attempting to walk, he would take a few steps and then be obliged to sit down, as there was an irresistible tendency to fall forwards or laterally. Gradually, however, these symptoms subsided, and in time he got so that he could go about the grounds freely. The sensation of bigness, however, and the deafness, continued. He was discharged June 2, 1879.

Case 2.—J. M., age 35, admitted March 12, 1879, was in the hold of a vessel assisting to unload iron ore; a bucket of it was spilled, and a piece struck him upon the right side of the head in the parieto-occipital region. There was a lacerated wound of the scalp, and a fracture of the skull, but no depression. The patient was unconscious at first, but soon recovered his senses. There was continuous bleeding from the ear, and a diagnosis of fracture leading through the petrous bone toward the base was made.

Cold compresses and rest were ordered, with medium diet. During the progress of the case an abscess formed under the scalp, which discharged freely. After this no untoward symptoms occurred, and by the 21st of April, the patient feeling able to go to work, left the hospital.

Case 3.—This was an extraordinary one. E. A. D., aged 40, on April 27, 1879, walked into the hospital and up stairs. The top of his head was in a horrible condition. There was a lacerated wound three inches long by one and a half wide, and very deep. The integument had sloughed or been torn away, the bones were missing, the dura mater was exposed and sloughing, and the brain could be seen pulsating in the foul mass, which it seemed to be trying to pump out. The patient was perfectly rational, and gave the following account of himself:—

He was first officer in a three-masted schooner sailing from the West Indies to New York with a cargo of sugar. He had worked very hard at loading the vessel in the heat, and for two days and nights after sailing for home he was constantly on the watch. He suddenly became ill, and conceived the idea that the captain and crew were going to murder him and throw him overboard. To frustrate them he thought he would take his own life, and tried to jump overboard, but was prevented from doing so. On the fourth day out, when off Cape Hatteras, he got possession of an axe and dealt himself several severe blows on the top of the head with the handle, fracturing the skull. He then, with the sharp edge, chopped out the softened mass, and picked away pieces of the bones. After this he got better and returned to normal consciousness. On the 25th, four days after inflicting the injury, the vessel arrived at New York. The patient walked to the cars and came to Philadelphia.

He said he was a temperate man, that he only took an occasional drink, and that he was not in delirium tremens. His appearance certainly did not indicate a man of intemperate habits. His story was so unlikely that it was of course doubted, but no inquiry elicited any other statement, and he persisted in it to the last, bringing no accusation against any one—in fact volunteering the declaration that the captain and crew were the best he had ever sailed with.

The sloughs were partially cleared away, several small pieces of bone were removed, cold compresses with mild antiseptics were applied, and a nourishing diet ordered.

The patient was in the third story. I feared he might attempt to jump from the window, and so ordered him to a private room in the basement. He remained there for one night, but protested against it, and earnestly requested to be sent back to his old quarters, saying that he knew perfectly well what he was about, and that it was too much like a prison down stairs. His request was complied with, and there was no trouble.

By May 1st, more serious symptoms set in. There was high fever and a quick pulse. The temperature was 1½ degrees higher on the right side than upon the left. This side was the seat of spasmodic twitchings and contractions, and by the

4th it became completely paralyzed. A hernia cerebri was also beginning in the wound, and there was some stupor. There was no facial palsy. On the 5th there was an attack of erysipelas, from which the patient recovered in a few days. Discharges had in the mean time been thrown off freely from the wound, and on the 7th an interesting event occurred. Dr. McIlwaine, while dressing the wound, saw the end of a piece of bone deep down in its anterior part and to the right side about an inch in front of the coronal suture. This and another piece he removed. These were pressing upon the right hemispheres in this position. There was some venous hemorrhage, and a small black clot, which was also taken out. The pieces were respectively ¼ by ½ an inch and ¾ by ⅜ of an inch in size. They had been actually driven down and buried under the sound part of the skull by the force of the blows, and were only exposed by the cleaning up of the wound. Almost immediately the paraplegia in the left arm was relieved, and by the next day that in the leg had also disappeared. The stupor was gone. The patient said he felt more rational, and he could bring his will to bear upon any desired movement, although he was weak.

This relief proved, however, to be but temporary. From day to day signs of brain disorganization and abscess were apparent. The paralysis returned, at first more manifest on the left side, but before death it became general. The intelligence was good up to within a few days of death, as rational answers were given to questions. There was no active delirium. There was much fever, the temperature chart showing a range from as low as 98½ on the 19th of May up to 106½ on the 31st. Control over the bladder and bowels was lost. On the 31st of May there was entire unconsciousness, and death took place at 2 P.M., June 1st.

Autopsy.—After the scalp was removed numerous linear chips of bone were found, and many linear scratches, 25 or more, which were made with a sharp instrument, were upon the outer faces of the frontal and parietal bones, and all were in a parallel line with the opening in the calvaria. This was three inches long and one inch wide. One inch in length was taken out of the frontal bone and the rest was from the parietals. There was an abscess leading from the base of the cerebral hernia to the corpus callosum. An abscess was in each hemisphere. Pus was infiltrated between the cerebrum and cerebellum. The dura mater was torn and thickened near the posterior portion of the wound, and here also there was abscess. The lateral ventricles were filled with serum. At the bottom of the longitudinal fissure there was a piece of bone ½ an inch long and 4 lines wide, about which there was an abscess.

Case 4.—P. McD., aged 29, was struck on the right side of the head with a loaded cane. Admitted May 5, 1879. Above the top of the ear and about half way between it and the sagittal suture there was a lacerated wound of the scalp leading down to a deeply depressed fracture of the skull. There was partial paralysis of the left arm. It could be raised from the shoulder, but there was no ability to move the fingers.

After a consultation on the 6th, I etherized the patient and enlarged the wound, then trephined the skull and elevated the depressed bone, removing a portion of it, and also a black clot which lay between it and the dura mater. This membrane was not wounded. The depressed brain arose after the operation, and could be seen pulsating at the bottom of the wound. An opening, altogether about ¾ of an inch in diameter, was made in the skull. The edges of the scalp wound were brought together by a pin, and sustained in position by a compress; rest and ordinary diet were prescribed. On the next day the paralytic symptoms were decidedly better, although there was some twitching. The patient now improved steadily, and by the 17th the grip of the left hand was normal. There was still some slight numbness of fingers. He is still in the house, June 16th, but goes about without difficulty. The wound is granulating slowly; several small pieces of bone have been taken away from it, being the necrosed edges of the opening. When in court recently (for the case is a judicial one), the patient felt some dizziness, which soon passed away. There is every prospect of his being able to leave the house shortly.

Case 5.—A. J., aged 24, admitted May 6, 1879. In a row he was struck with the handle of a pistol upon the left side of the forehead, immediately above the external angular process. There was a lacerated wound of the integument, at the bottom of which was an extensive depressed fracture of the skull. The brain was wounded, and portions of it were exuding. The membranes were of course torn. There was no paralysis. In addition to the skull fracture, there was a fracture of the jaw near the symphysis.

On the 7th, I enlarged the external wound, the patient being under ether. There was no necessity of applying the trephine, for I could get the elevator beneath the edges of the broken fragments, some of which were tilted in, and pressing directly into the lacerated brain. I removed one large loose piece of bone and some fragments, altogether measuring about one inch and a half in diameter. The rest of the depressed portion was elevated and left *in situ*. After the hemorrhage ceased the wound was closed with adhesive strips and compresses. A Barton's bandage was used for the broken jaw.

This patient made a rapid recovery. No untoward head symptom whatever occurred. The jaw gave him much more annoyance and pain than the head. By the 7th of June he was well of both injuries, and was discharged.

Case 6.—W. D., aged 14, was beaten about the head while in a wagon. Admitted May 13, 1879. He was insensible, and when he got home he was thought to be intoxicated, and allowed to lie upon the floor all night. There was considerable hemorrhage from the nose. He was brought to the hospital in the evening of the following day. There was a great deal of swelling and infiltration over the right parietal protruberance, but no open wound; a depressed fracture could be felt through the softened tissue. The patient was semi-comatose, but could be easily roused. There was partial paralysis of the left arm and hand. Rest, cold compresses to head, and milk diet were ordered.

Before a formal consultation could be held upon this case he was removed by his parents to his home. My own intention was to treat him expectantly, and to await events.

From an interest in the case, the resident physicians have visited the patient at his home. The infiltration has subsided, and the fracture can be easily made out. The paralytic symptoms were better.

On June 12th, another visit was made. The boy was playing in the streets, and has been out of bed for some time. The mother states that from being a good boy he is now very irritable; his memory is impaired. The grip of the left hand is nearly normal; sometimes he cannot hold his knife or bread without first fixing them with the other hand. In the mornings the right side of the face is swollen, and there is spasmodic action sometimes of the left arm. There is slight ptosis of right upper lid. The vision is impaired; sometimes it is double. Pressure at seat of fracture gives pain.

Case 7.—D. M., aged 9, admitted May 25, 1879, was kicked by a horse while playing in a stable. There was a lacerated wound and a large somewhat depressed fracture of the right frontal bone on its lateral aspect, and immediately over the outer portion of the superciliary ridge. The eyelid hung down on account of the laceration, and not through paralysis. The wound was approximated by adhesive strips. Cold-water compresses were applied. There was a complete absence of symptoms of pressure at the time of injury, and nothing has occurred since to warrant operative interference. The patient has had an attack of erysipelas, from which he has recovered. The wound now, June 17th, has nearly healed, although rest in bed is still enjoined.

You will notice that most of these patients were in the wards at the same time. For the community it would seem to be a bad, for the doctors, a good year for heads.

What a wealth of clinical observation is open to us in these cases. They are replete with interest for the surgeon, for the physiologist, and for the medical jurist. Notice the regions that are involved. The base and parieto-occipital, in Nos. 1 and 2; the vertex and centre involving both cerebral hemispheres in No. 3. The lateral over right middle lobes in Nos. 4 and 6. Anterior over left frontal lobe in No. 5, and anterior over right frontal in No. 7. The brain itself was visibly lacerated in two, and in all it was seriously involved. Notice that some of the cases were actively interfered with by the surgeon; but that most of them were carried through on the expectant plan.

In the résumé, I have not by any means told you of all that was done. That would be tedious detail for which we have not time in a lecture like this. I am only able to call your attention to the main points of interest. First we will take a mere glance at the physiological phenomena going from before backwards. Number 5, over the left frontal lobe in which there was laceration of the brain substance, and No. 7 over the right frontal lobe, presented no abnormal deviations whatever as regards the nervous system. I have had frequent occasion to notice the enormous amount of injury which this portion of the cranium and its contents will sometimes sustain without apparent permanent damage. You have some clue to an understanding of this when you call to mind that the cranial nerves originate posteriorly to the fissure of Sylvius, and that their course to the points of emergence is wonderfully well protected from injury or shock. They are overhung by shelves of bone, are imbedded in connecting tissue run in grooves by the sides of bloodvessels or in the brain substance itself, the convolutions of which often protect them. I think they are very rarely torn across or lacerated, and that when paralytic symptoms following accidents, and involving them occur, these are due to pressure upon some portion of their course. Disease, however originating, may disorganize them. When paralysis therefore follows injuries of the anterior portion of the cranium, it may be assumed that the shock is very profound through pressure of blood clot, or through deep laceration of brain substance.

Cases Nos. 4 and 6 involved the right middle lobes near the parietal protuberances. Both of these were accompanied by left sided paralysis, illustrating the cross action and distribution of the nerve fibres. Fractures and brain injuries of these portions are nearly always accompanied with paralysis. If you will refer to the museums and to your books and illustrations you will find how abundant the connecting fibres are in the middle cerebral lobes.

Case No. 3 is of great interest. Here the top of the head was involved affecting both hemispheres. All pressure had been removed except where the bones had been driven in as described at the anterior part. These did not at first produce any immediate paralysis. It was not until the 13th day after the injury, that the left side of the patient became powerless. Here you have a fine illustration of the tolerance of the anterior lobes, for it would seem that the pieces of buried bone, large as they were, had to set up a certain amount of harassment and extension of irritation before the motor tract was involved. Both motion and sensation returned when the bones were removed, but the injury was too profound for the amelioration to continue.

Nos. 1 and 2 were undoubted fractures of the base, the first probably involving the crura and pons by pressure, for recovery would not have occurred so promptly had there been laceration. The want of co-ordination and the tendency to fall forward and laterally, certainly indicated an inclusion of nerve substance in the injury. The deafness was due to actual fracture I believe of the petrous bone, and not to laceration of the auditory nerve within the cavity of the cranium. No. 2 presented no extra phenomena. I believe he sustained a mere fissure of the bones and that the nerve structures escaped.

I said that in these cases we had something for the medical jurist. No. 3 is the only one I shall speak about in this connection and that on account of its curious interest and importance. I did not at first believe the man's strange story.

I should not have been surprised to have heard of an arrest of some of his seafaring companions for murder, immediately after his death, if they could have been found. In fact if his friends do not know what we know, an arrest may yet take place. But it would be useless, for we now know from the post-mortem examination, that the poor fellow's story incredible as it seemed to be, was true. The proof of this is that the calvaria, or skull cap, which we have fortunately preserved, has twenty five or more superficial slits and scratches, running parallel with the opening and of exactly the kind that the edge of a sharp axe would make. Now no murderer or set of murderers would have made such marks as these, and have inflicted them all in one direction. A few strokes or even one would have sufficed for them. Imagine the number of blows that our sailor must have given himself, if twenty-five marks of the axe are to be counted about the opening in the otherwise sound bone.

My belief is that this man was frenzied with heat, fever, and exhaustion,

> "The sky and the sea and the sea and the sky
> Lay like a load on his weary eye;"

the burden was more than he could bear, and hence the terrible act to rid himself of it.

We will now consider the diagnosis, prognosis, and treatment of these cases. The diagnosis as to the presence of a fracture is easy when it is compound, that is, when there is an external wound communicating with the broken bones. Often these may be seen, and if not, they may be felt.

The finger is the best probe, if the wound in the scalp is too small to admit it, the wound may be easily enlarged. Artificial probes should be used sparingly, and with a light hand. Having ascertained the presence of a fracture it is not by any means so easy to determine its extent. We have seen in the cases recited, that the opinions as to extent were sometimes founded upon the rational rather than upon the physical signs. An apparently small fracture may have numerous fissures radiating from it. The extent of a fracture at the base can only be surmised.

When the injury is not compound the case is entirely different, and it is very often by no means easy to make out. Very many mistakes have been made, and often rash opinions have been given. There is no region of the body so deceptive to the sense of touch as the scalp. I will ask you, as I always do when speaking on this subject, to feel your own heads. There is no idea whatever conveyed to you as to the thickness of the bone covering. It seems as though a piece of parchment would correspond with it, when in reality the integument varies from one-eighth to one-quarter of an inch in thickness. This is owing to the dense connective tissue of which it is composed, and beneath this is the occipito-frontalis, in part muscular, in part tendinous; at the sides are the temporal fascias and muscles. I have often seen a defined portion of this dense structure mashed into a jelly and infiltrated. The definition was made by the uninjured borders of the same parts, and then, even to the initiated, would give the sensation of hard, jagged edges of bone. The deceit is often complete, and the rational symptoms must be carefully studied. These cases are emphatically the ones in which we must wait, for while the experienced surgeon will know what he feels, he may not be able to say that there is no fracture beneath the injured portion. Dr. W. E. Horner used quaintly to say, "Doctor, it is very hard to tell what is under the skin." How very true this is as to the head. Recently we have had a curious case in our courts bearing upon this point; a man, over sixty years of age, was tried for a most foul murder, that of his own daughter. There was no difficulty in proving his guilt, in fact, he acknowledged the deed. His counsel, however, put in a plea to mitigate the severity of sentence founded upon the fact that there was a depression upon the left side of his head, the result of a fracture received many years before, and that owing to this injury he was subject to uncontrollable fits of passion, in other words, to fits of temporary insanity. The prisoner's own statement was, when asked whether he had ever received an injury of the head, that he remembered his skull being fractured when he was 17 or 18 years of age. He also said that he was trephined. By the rules of law his own statement was not admitted, and so the matter was left to the doctors. The head was examined by several of them. One only was positive as to a fracture. The others varied in opinion from the probability of a fracture having existed to a disbelief in any such injury. No history of the man experiencing through life, or at intervals, consequences which, without strain, could be attributed to a depressed fracture was obtained. No one would say upon his oath that the skull never was fractured, but they would say that the prisoner had no abnormal record that could be fairly attributed to such an accident. An opportunity soon occurred which was thought would settle the question. The prisoner was found guilty, and immediately after sentence committed suicide. At the autopsy, there was a projection into the cavity of the cranium corresponding with the depression, but the brain and membranes were perfectly healthy. It is certain that the man was never trephined. I think the positive doctor was right as to the fracture, but that the prisoner's lawyers were wrong as to their inferences. I must admit, however, that the specimen obtained is open to debate, and that opinions are divided as to its nature. In any society analogous to that of the Stanislaus, it might give rise to "subsequent proceedings."

The outer or exposed aspect of the fracture is by no means an index to what may exist within. Extensive injuries of the external table may occur without the internal table being involved, and, on the contrary, punctured wounds and gunshot frequently impress their destructive forces almost altogether upon the internal table. This is often illustrated in the neighbourhood of the frontal sinuses. [The season does not appear to be over yet, for while I am writing this out, No. 8, a negro woman has come into the wards with the front table of her sinus over the right brow broken through and driven in. She is said to have been struck with the edge of a stove plate. The inner table is also broken, for the brain may be seen pulsating in the wound. There is no paralysis or other serious symptom.] In this position great injuries are sustained, and yet the brain may be but little or not at all involved. I have known the delicate fat of the orbit projecting in small lobes, amongst the blood and broken bones, to be taken for cerebral substance.

In children, the sinuses are either absent or but slightly developed, and often may be said not to exist before puberty. The youngsters, however, stand fearful knocks in this position. It may be that the provision for the future development of the sinuses has something to do with this toleration.

The prognosis of these fractures should always be guarded both as to immediate and as to subsequent results. The nature, the extent, and the position of the injury are all to be considered. A small punctured fracture, driving in the internal table, may be more dangerous to life than an extensive injury which is completely exposed.

Now as to treatment. It has been indicated in my report of the cases. You will observe that I am governed by no arbitrary rules. Each case must be a study for itself.

I say, that if right before your eyes there is an open wound with a badly depressed fracture, enlarge the wound if necessary to give yourself room, trephine and elevate. It may not be necessary to use the trephine if fragments of bone are turned on their edges into the brain substance; the elevator and forceps will be the necessary instruments here.

If there is no external wound, but an undoubted fracture, and no symptoms indicating brain injury, wait. If symptoms of undoubted brain involvement arise, cut down upon the bone, and be guided by what you find. You have thrown your case into one of the first kind above mentioned, and must act accordingly.

The after treatment is simple. Water, or carbolized oil dressings, with rest and moderate diet, and strict attention to the functions of the bladder and bowels, will generally be all sufficient. There should be no exciting surroundings.

Cases that do not require operative proceedings should be treated in the same manner from the beginning. All should be let alone if doing well; if not, symptoms must be treated as they arise.

Operative interference is by no means free from danger. In one case I saw the longitudinal sinus opened. A spiculum of bone belonging to a detached fragment had been driven into the great blood channel, and was acting as a plug. When the fragment was removed the hemorrhage was frightful. It was checked, however, and the patient lived for some days. Again, I once removed a depressed piece of bone, and exposed the middle artery of the dura mater, which was torn. The patient bled to syncope, but eventually revived and made a good recovery. Again, I know of a case where a fragment of bone was protecting the end of a vessel. It was removed, and the patient was dead in half an hour from hemorrhage.

Plugs of wood, as from a piece of match or a cedar pencil, compresses, digital pressure, water (either cold or hot), may be all resorted to on these trying occasions. My time is out, and I must refer you to the books for details.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Mortality Statistics of the United States.—With a view to making the vital statistics of the United States far more complete and comprehensive than they have ever been, the Superintendent of the Tenth Census has appealed to the medical practitioners throughout the country to lend their aid to the accomplishment of this desirable result. To this end the Superintendent of the Census has forwarded to each physician whose address he possessed, a book of blanks in which to make a record of all deaths occurring in his practice during the year beginning June 1, 1879, and ending May 31, 1880. Any physician who has not already received a copy, can doubtless obtain one by applying to the Superintendent of the Census, Department of the Interior, Washington. The Census Bureau liberally offers to reimburse the cost of stamps used in correspondence growing out of this service, and it is to be hoped that the Bureau will receive the earnest and faithful co-operation of the entire profession in the important labour it has undertaken.

The American Ophthalmological Society will hold its fifteenth annual meeting at the Aquidneck House, New York, July 24th.

The Connecticut Medical Society held its eighty-eighth annual session at Hartford, May 28th and 29th, under the presidency of Dr. C. M. Carleton. The following office-bearers were elected for the ensuing year: President, H. R. Goodrich, M.D., of Vernon; Vice-President, Dr. G. S. Platt, of Waterbury; Secretary, Dr. C. W. Chamberlain, of Hartford. Drs. Francis Bacon, of New Haven, and B. N. Comings, of New Britain, were appointed delegates to the International Medical Congress, which meets at Amsterdam in September.

The next annual meeting will be held at New Haven.

Medical Society of the State of New Jersey.—The one hundred and thirteenth annual meeting of this Society was held at Englewood, May 27th and 28th, Dr. John S. Cook, of Hackettstown, President, in the chair. The following officers were elected for the ensuing year: President, Dr. A. W. Rogers, of Paterson; Vice-Presidents, Drs. A. N. Dougherty, of Newark, L. W. Oakley, of Elizabeth, and John W. Snowden, of Waterford; Secretary, Dr. Wm. Pierson, Jr., of Orange. The next annual meeting will be held at Princeton.

Medical Society of the State of Pennsylvania.—The thirtieth annual meeting of this society was convened at Chester, May 21st, under the presidency of Dr. James L. Steuart, of Erie. The Society decided to meet next year at Altoona, on the third Wednesday of May, and elected the following officers: President, Andrew Nebinger, M.D., of Philadelphia; Vice-Presidents, Drs. Wm. B. Ulrich, of Delaware Co.; Jacob L. Zeigler, of Lancaster Co.; Geo. A. Lynn, of Washington Co.; and Joseph A. Murphy, of Luzerne Co.

State Medical Society of Illinois.—The annual meeting of this Society was held at Lincoln, May 20th, Dr. E. P. Cook, of Mendota, President, in the chair. The following officers were elected for the ensuing year: President, E. Ingals, M.D., of Chicago; Vice-Presidents, Drs. G. W. Jones, of Danville, and C. C. Hunt, of Dixon; Secretary, N S. Davis, M.D., of Chicago. The Society determined to meet next year in Belleville.

Tennessee State Medical Society.—The forty-ninth annual meeting of this society was held at Nashville, on April 1st, Dr. R. F. Evans, of Shelbyville, President, in the chair.

Dr. T. A. Atchison, from the committee on the Eve monument, reported that "after careful deliberation the committee recommend that the State Medical Society establish the Eve prize fund of one thousand dollars, the interest of which shall be appropriated as shall hereafter be directed, as a prize for the best essay upon topics belonging to the department of surgery as the society may designate. They furthermore recommend that the action taken by the society at Memphis in reference to a monument for Dr. Paul F. Eve be rescinded, and the above memorial prize fund to be raised in lieu of said monument." The report was adopted.

The following officers were elected for the ensuing year: President, E. M. Wright, M.D., of Hamilton; Vice Presidents, Dr. B. B. Lenoir, of Knox; N. F. Tucker, of Davidson; and G. B. Thornton, of Shelby; Secretary, Dr. J. Berrien Lindsley, of Davidson Knoxville was selected as the place of meeting for next year.

Medical and Chirurgical Faculty of Maryland.—The eighty-first annual session of this society convened in Baltimore on April 8th. Dr. Jas Carey Thomas, of Baltimore, Vice-President, in the chair, owing to the absence, from illness, of President Samuel P. Smith, of Cumberland. The following officers were elected for the ensuing year: President, S. C. Chew, M.D.; Vice-Presidents, Drs. H. P. C. Wilson, and Jas. A. Steuart; Secretary, Dr. W. G. Regester.

Louisiana State Medical Society.—The annual meeting of this society was held at New Orleans, on April 9th, Vice-President Bemiss in the chair. Several papers were read, among others one by Dr. L. F. Salomon, on the cases of leprosy occurring in Louisiana; it is *not* stated that the lepers are Chinese. The following officers were elected for the ensuing year: President, J. W. Dupree, M.D., of Baton Rouge; Vice-Presidents, Drs. Wilkinson, Sr., J. P. Davidson, P. O. Postell, A. A. Lynn, P. Chew, and O. P. Longworthy; Secretary, Dr. Thos. Layton. The next annual meeting will be held in New Orleans, on the last Wednesday in March, 1879.

California State Medical Society.—The ninth annual meeting of this Society was held at San Francisco on 17th and 18th of April, Dr. Henry S. Orme, of Los Angeles, President, in the chair. The following officers were elected for the ensuing year: President, Dr. A. W. Saxe, of Santa Clara; Vice-Presidents, Drs. J. W. Todd, of Stockton, J. M. Bricelaud, of Shasta, C. G. Kenyon, of San Francisco, and W. A. Washington, of Merced. The next meeting will be held in San Francisco.

University of Pennsylvania.—It is announced that in the Medical Department, on and after Oct. 1880, a preliminary examination will be instituted, which every candidate, who has not previously received a collegiate degree, must pass. The applicant will be required: First, to write a brief essay, not exceeding a page of foolscap, which will serve as a test of his qualifications in orthography and grammar; Second, to undergo an examination in the elementary principles of Physics, as contained in Fownes's Chemistry; Third, to pass an examination in easy Latin prose translation (First Book of Cæsar's Commentaries). In lieu of Latin, any language other than English may be substituted.

University of the City of New York—Prof. John T. Darby has resigned the Chair of Surgery in this institution and has been elected Emeritus Professor, and

Dr. Joseph W. Howe has resigned the Chair of Clinical Surgery. Prof. J. Williston Wright has been transferred from the Chair of Obstetrics and Diseases of Women and Children to that of Surgery, and Prof. William M. Polk, formerly Professor of Therapeutics and Materia Medica in Bellevue Hospital Medical College, has been elected to the Professorship of Obstetrics and Diseases of Women and Children in the University.

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College of Physicians and Surgeons.—Dr. Henry B. Sands has resigned the Chair of Anatomy and been elected Professor of the Practice of Surgery, and Dr. Markoe assumes the title of Professor of the Principles of Surgery. Dr. T. Gaillard Thomas's professorship has been changed to that of the Principles of Gynæcology, and his former Adjunct, Dr. James W. McLane, has been made Professor of Obstetrics and Diseases of Children. Dr. Thomas T. Sabine has been elected to the vacant Chair of Anatomy.

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Bellevue Hospital Medical College.—Dr. Joseph W. Howe, formerly Professor of Clinical Surgery in the University of the City of New York, has been elected Clinical Professor of Surgery in this institution; and Dr. A. A. Smith has been transferred from the lectureship upon Clinical Medicine to one upon Therapeutics, Materia Medica, and Clinical Medicine.

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Monument to Ephraim McDowell.—The Kentucky State Medical Society, on the occasion of its annual meeting at Danville, on May 14th, dedicated a handsome granite obelisk, thirty feet high, to the memory of Dr. Ephraim McDowell, the Father of Ovariotomy. The monument bears the following inscriptions:—

"Ephraim McDowell, M.D., born in Rockbridge County, Va., Nov. 11, 1771; came to Kentucky in 1782; attended the University of Edinburgh in 1793 and 1794; located at Danville in 1795; performed his first ovariotomy in Danville in 1809; died in Danville, June 25, 1830."

"To the memory of Ephraim McDowell, who, in inaugurating a great surgical operation, became a great benefactor to his race."

"Erected by the Kentucky State Medical Society, 1879."

"Honour to whom honour is due."

Upon the invitation of the Society, the dedicatory oration was delivered by Dr. S. D. Gross, and the selection was very appropriate, for it was through his efforts in 1852 that McDowell's claims to priority in the performance of this operation were substantiated. The address was largely historical, and elicited universal commendation. At its conclusion, as a memento of the occasion, Dr. Gross was presented by the State Society with the antique bronze knocker, of handsome workmanship, which had hung on the door of the residence at Danville of the great ovariotomist.

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The Medical Herald is a new monthly, edited and published by Dudley S. Reynolds, M.D., at Louisville, Ky. In its salutatory the editor frankly states that it is not intended to fill a hiatus in medical literature, nor is it undertaken to supply a want long felt by any one, but that it will live within the code of ethics, that it will not indulge in personalities of a controversial nature, and will not advocate exclusive interests. The first number, which is dated May, contains several interesting articles, and presents an attractive appearance. We trust that it may so live up to its good intentions as to reap the reward of success which they deserve.

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Personal.—Dr. J. LAWRENCE SMITH, of Louisville, formerly Prof. of Chemistry in the Medical Department of the University of Louisville, has been elected a member of the National Academy of Science of France, to succeed Sir Charles Lyell, of England, lately deceased.

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OBITUARY RECORD.—Died at New York, on the 9th of June, in the 43d year of his age, JOHN THOMSON DARBY, M.D., late Professor of Surgery in the University of the City of New York.

Dr. Darby was a native of South Carolina, a graduate of the University of Pennsylvania, and served with distinction throughout the war on the medical staff of the Confederate army. At the time of his death he was surgeon to Bellevue and to Mt. Sinai Hospitals of New York.

FOREIGN INTELLIGENCE.

Nerve-Stretching in Tetanus.—M. THOMAS of Tours has forwarded to the Society of Surgery of Paris at its sitting of February 19th, the report of the case of a man, aged 28, who wounded the ball of the thumb by falling on the fragment of a bottle. Some days afterwards, *tetanus* appeared, with *opisthotonos* and *trismus* very marked, difficulty in swallowing, and convulsive contraction of the flexors of the arm and hand, except the thumb. To destroy the effect of the inflammation of the ends of the nerves, and their compression by the cicatrix, M. Thomas practised stretching of the median nerve at the level of the spot at which the humeral artery is usually tied under the biceps. The nerve was isolated and placed over a director and twice stretched. The patient felt himself immediately relieved. Two attacks of convulsions appeared afterwards in the course of the day, and then a third after two hours of sleep. The *trismus* and *opisthotonos* had disappeared that evening, and the patient was feeling well, when an attack of delirium occurred, during which he leaped out of his bed and walked about the ward; death followed in the evening. The *post-mortem* examination showed that the median nerve was congested at the level of the stretching; a rupture was found of the peripheral filaments of the nerve: the tendon of the long flexor of the thumb had been divided in the wound of the hand.—*British Med. Journal*, March 29, 1879.

A New Method of Treating Thoracic Aneurism.—M. CONSTANTIN PAUL has brought forward a new method of treating thoracic aneurism. According to him the improvement in the symptoms which follows galvano-puncture is equally satisfactory when acupuncture only is practised, and he affirms that this operation is completely innocuous. M. Dujardin-Beaumetz also believes that in Ciniselli's operation the clot formed at the pole within the sac is very trifling, the useful coagulum originating at the inflammatory spot on the wall of the vessel caused by the introduction of the needle. As, however, rupture of an aneurism more generally takes place internally, it is advisable to thicken, if possible, the inner wall, and this he proposes to effect at the next opportunity by complete transfixion of the tumour by the needle.—*Lancet*, April 5, 1879.

Large Salivary Calculus.—A case of large salivary calculus is recorded in the *Correspondzenblatt für Schweizer Aerzte*, March 1, 1879. The patient, a sailor, consulted the author respecting a swelling on the inner side of the horizontal branch of the lower jaw; it was of the size of a pigeon's egg, elastic and painful on pressure. The patient said that he had had similar swellings several times during the last two years, but that they had opened spontaneously. In examining the mouth, there was found to be a large hard movable swelling under the left side of the tongue. The Whartonian duct, which was much enlarged at its entrance, was laid open, and a large salivary calculus was extracted. Suppuration soon set in, and the opening of the duct cicatrised, but the saliva continued to flow from a small opening in the duct. The patient had never experienced any trouble in eating or speaking. The weight of the stone was 115¾ grains; it consisted of phosphate and carbonate of lime and magnesia. It was triangular, its largest circumference being 4½ inches, its length 1⅗ inches, and its breadth $\frac{9}{10}$ of an inch. The other swelling turned out to be a swollen submaxillary gland.—*British Med. Journal*, April 26, 1879.

Anæsthesia by administration of Protoxide of Nitrogen under Pressure.—M. REGNARD has reported to the Biological Society a third operation, performed under M. Bert's method of anæsthesia by protoxide of nitrogen under pressure, to which we have before referred. The case in question was one of resection of the superior maxillary nerve. It was performed by M. Péan in twenty minutes, without the patient having suffered and without any sort of accident. He, however, awoke for an instant during the course of the operation, but the cause of this accident was palpable. In consequence of the position in which the incisions had to be made, the mask which is usually employed for the inhalations could not be applied. Thus, the mechanism for administration being imperfect, a simple tube carried the gaseous mixture into the mouth, and the assistant closed the nostrils in order to prevent the patient from breathing pure air. The short awakening mentioned occurred then, whilst the assistant, having his attention drawn off, had left the nostrils open. As soon as they were again closed, the anæsthesia was again perfect. There was here, then, only a defective apparatus, which the want of time alone prevented from being remedied, but which was easily corrected.—*British Med. Journal*, April 26, 1879.

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The Influence of Brain Work on the Growth of the Skull and Brain.—Messrs. Lacassagne and Cliquet communicated an interesting paper on the subject to the Société de Méd. Publique et d'Hygiène professionelle. Having the patients, doctors, attendants, and officers of the Val de Grace at their disposal, they measured the heads of 190 doctors of medicine, 133 soldiers who had received an elementary instruction, 90 soldiers who could neither read nor write, and 91 soldiers who were prisoners. The instrument used was the same which hatters employ in measuring the heads of their customers; it is called the conformator, and gives a very correct idea of the proportions and dimensions of the heads in question. The results were in favour of the doctors; their frontal diameter was also much more considerable than that of the soldiers, etc. Nor are both halves of the head symmetrically developed; in students, the left frontal region is more developed than the right; in illiterate individuals, the right occipital region is larger than the left. The authors have derived the following conclusions from their experiments: 1. The heads of students who have worked much with their brains are much more developed than those of illiterate individuals, or such as have allowed their brains to remain inactive. 2. In students, the frontal region is more developed than the occipital region, or, if there should be any difference in favour of the latter, it is very small; while, in illiterate people, the latter region is the largest.—*London Med. Record*, April 15, 1879.

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The Action of Sewer-Gas on Lead and Zinc. — Mr. T. KINNEAR, Sanitary Inspector of Dundee, in his report for 1878 makes the following remarks on this subject:—

It is impossible to determine otherwise than by experience and observation how long an ordinary lead soil-pipe or trap will resist the action of sewer-gas before perforation takes place, but it is certain that a thick one will do so much longer than a thin one, and it is equally true that one efficiently ventilated will serve nearly double the time of one continuously air-bound. I have paid particular attention to the action of sewer-gas on zinc rhones on eaves of buildings, where it was striking on the under part, and found in the course of a couple of years or so pretty large holes eaten completely through, showing that that material could not long withstand the effect of the gas. Lead is, of course, more durable than zinc, but the difference is only a question of degree, as shown by the fact that, in not a few of the water-closets repaired by the officers of the department during the year, small apertures were found in the main vertical lead pipe, and in the cross or horizontal one leading from it to the trap of the closet various perforations were found on the top, indicating clearly the operation of foul air from the drain. Lead traps and soil-pipes from water-closets, baths, and fixed basins are all subject to tear and wear, but the traps, being burdened with the additional strain of barring the passage of sewer-gas, do their work less efficiently and for a much shorter period than they are generally credited with; hence the necessity for proper ventilation and occasional inspection. There is often considerable indifference shown by many plumbers when sent by their masters to examine into complaints of smell supposed to be coming from lavatory appliances. They usually look for a fluid leakage; and when that is not perceptible they leave, declaring to the complainer that the pipes are all right, when probably a little longer time spent in making a more complete examination would have revealed that such was not the case. They seem to imagine that it is the liquid only which wears holes, and do not even dream that the gas from the drain is the most powerful agent of the two as an element of mischief. This is another fruitful means by which sorrow is brought to many a home. It is indisputable that drain air accelerates decay in lead fittings, and these and their drain connections ought to be periodically examined. To facilitate this they should be placed in a position of easy access, with their covering left to open freely, and not hidden in an out-of-the-way corner as they usually are. Sewage-gas being known to be a lurking and a fatal source of disease, which proves largely fatal, it is amazing with what apathy many people of more than average intelligence view the matter of branch drains and relative internal fittings.—*Sanitary Record*, May 16, 1879.

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Cheilo-Angioscopy.—Professor Hueter, of Greifswald, who has lately furnished us with the method of which an account has been given in this journal under the title of "Dermatophony," now sends to the *Centralblatt Med. Wiss.* (Nos. 13, 14, 1879) a preliminary notice of a new discovery of his by which the capillary circulation of the blood can be observed in the human subject. He uses for this purpose the mucous membrane of the internal surface of the lower lip. The head of the examinee is fixed in a kind of photographer's head-rest, which is furnished with a chin-piece to which the microscope and the illuminating apparatus are attached. The lip is everted and fixed with forceps of special construction placed near the angles of the month. The circulation can be examined either by day or lamp-light; in either case a strong convex lens is used to concentrate the light on the part. Professor Hueter has only used a comparatively low power, magnifying about fifty-two times, in the examinations he has as yet made. The first impression produced by a look through the microscope is that of a very fine injected preparation, but on choosing some well-illuminated superficial vessel for observation the movement of the blood can be seen. The red corpuscles look like fine points, the white like whitish rounded specks. The circulation in the capillaries of the lower lip is slower than in those of the third eyelid of rabbits and dogs; in the larger veins, on the other hand, it is rapid. The openings of the mucous glands can be seen surrounded by capillary vessels, and in the parts adjacent to the exterior of the lip the pavement epithelium can be made out under very oblique illumination while the blood-vessels are obscured. Pathologically, by compressing a part of the lip with an eyelid forceps, the phenomena of venous stasis can be observed without much distress to the patient, if the experiment be not prolonged more than a few minutes. Professor Hueter believes that he has made out that, as in the mesentery of the frog, so in the human lip, a number of capillaries exist, which, under normal blood-pressure only, contain plasma, or, at most, a few occasional red corpuscles. These "*plasmatic*" capillaries, as he terms them, only fill with red blood-cells during venous stasis. The removal of pressure from the lip is followed in about ten minutes by the return of a normal circulation.

The application of ice to the mucous membrane causes instant arrest of the capillary circulation, probably from contraction of the smallest arteries; but in a few seconds all goes on as before. Chemical agents, the best of which is glycerine, cause slight aggregation of the red corpuscles, and irregularity of the flow, but without permanent stasis, and the phenomenon only lasts a few seconds.

Professor Hueter has not been fortunate enough to examine the circulation of the lip in any marked cases of septic fever, as Lister's method has rendered them few and far between in his clinic. Such cases as he has observed exhibited aggregation of the red corpuscles and momentary arrest of the blood-current, alternating with a sudden return of motion and onward rush of the aggregated corpuscles. In chronic suppuration, an increase in the number of white blood-cells is easily detected, and all kinds of disturbances of the circulation occur in the finer vessels—mainly, however, owing to aggregation, not of the red corpuscles, but of the white. Where fever with evening exacerbations is present, these disturbances intensify as the temperature rises. Professor Hueter recommends the lips of scrofulous children to begin the study of "cheilo-angioscopy" on. Scrofulous adults often have a thickened epithelium, which blurs the vessels. The method is not available for clinical purposes without some practice. No doubt it will before long be applied to several febrile diseases, to which Professor Hueter makes no allusion—for example, facial erysipelas, and the acute exanthemata, especially scarlet fever. By very powerful illumination—by the electric or the lime light—possibly numerous lenses might be available. At present we must be content with what the discoverer tells us.—*Med. Times and Gazette*, May 10, 1879.

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Coloured Printing Paper.—M. JAVAL has given some further explanations, at the Société de Biologie at its sitting of February 22d, of the reasons why the yellow colour is the best for printing-paper. The eye is not achromatic. All light comprising various colours of the spectrum produces on the retina circles of diffusion. The only means of avoiding these would be to employ a monochromatic light; but this, whatever it might be, would be insufficient. Since it is not possible to suppress, without inconvenience, six of the colours of the spectrum, it is at least possible to eliminate them to the utmost extent by attacking them either on the side of the red or on the side of the violet. In the first case, we are deprived at the outset of too considerable a quantity of light, and we fall again into the inconvenience of monochromatic lights. In the second, one can without any disadvantage cut off the violet, the indigo, or the blue. The truncated spectrum which then remains will necessarily give less numerous and less extended circles of diffusion on the retina. Now the colour which results from the composition of this demi-spectrum is just the yellow colour, and not yellow of every tint, but that which is naturally seen in the yellow colour of wood paper or chamois leather; and, for this reason, this colour is recommended by M. Javal for printing paper, as being the most healthy from the point of view of hygiene of the eye.—*British Med. Journal*, April 12, 1879.

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The Use of the Forceps in Labour.—A discussion "On the Use of the Forceps and its alternatives in Lingering Labour," will be opened by Dr. BARNES at the meeting of the Obstetrical Society of London, on May 7th. The terms of the subject, which have been decided by the council, exclude from discussion the use of the forceps to expedite labour, on account of convulsions, hemorrhage, prolapse of the cord, or other accidental complications. The forceps comes into competition with its alternatives expectancy, ergot, lever, or compression of the uterus under two leading orders of cases: 1. When the head is delayed in the pelvic cavity; 2. When the head is delayed at, or above, the brim. The chief contest turns upon the use of the forceps in the second order of cases. This involves discussion of the following questions: 1. Does lingering labour occur so as to entail danger to mother or child during the first stage of labour? 2. Is the application of the forceps ever necessary or useful before the full dilatation of the cervix uteri? It will be contended that those who rarely use the forceps more frequently resort to ergot or craniotomy, especially where the head is arrested above the reach of the short forceps. The following general propositions will be offered: 1. In lingering labour where the head is arrested in the pelvic cavity, the forceps will almost always be better than its alternative. 2. In lingering labour where the head is engaged in the pelvic brim, and where it is known that the pelvis is well formed and the head normal, the forceps will be generally better than its alternatives. 3. In lingering labour where the head is resting on the pelvic brim, the liquor amnii discharged, and it is known that there is no disproportion, or only a minor degree of disproportion, even although the cervix uteri is not fully dilated, the forceps will generally be better than its alternatives. 4. In proportion as the head is high in the pelvis, in the brim, or above the brim, the necessity, the utility, and the safety of the forceps become less frequent. 5. As a corollary under the conditions of the preceding proposition, increasing caution is called for in determining on the use of the forceps, and greater skill in carrying out the operation.—*British Med. Journal*, April 26, 1879.

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Tarantulism.—The following recently observed case of tarantulism has been published in *Il Morgagni*, by Dr. CAMPBELLI. A woman, aged 29, was stung by a tarantula. A few moments after the accident, she began to feel very ill, threw herself on the ground, and complained of violent pains in the arm, together with a sensation of tearing in the joints. She was taken into the town, and, when seen by the doctor, could only breathe with difficulty, and became so furious that she could not be kept in bed. Her pulse was only 50 and very weak; the temperature was low. On examining the wound, nothing could be seen except two little darkened spots, which seemed to have been made by a pointed instrument; they were surrounded by a swelling of the size of a chestnut. A cruciform incision was made into the bottom part, and a ligature applied to the lower part of the arm. The incised parts were anæsthetized to the depth of two-fifths of an inch. After the wound had sufficiently bled, it was cauterized with nitric acid, and stimulating medicine was given internally. On the second day, the patient had another attack of mania, and at the same time complained of abdominal pains; her tongue was furred, she was thirsty, had no appetite, vomited, and her bowels did not move till the third day. On the fourth day, the patient slumbered at intervals, and her lips were covered with a frothy saliva. Her right hand executed movements, as if playing on the guitar, and the patient accompanied them with songs; in short, it was a typical form of tarantulism. The patient then began slowly to recover, and was well on the sixth day. The author points out that the most curious symptom of tarantulism consisted in the choreiform movements, which led him to employ antispasmodic and stimulating drugs.—*British Medical Journal*, April 26, 1879.

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International Medical Congress, 1879.—The sixth International Medical Congress will be held at Amsterdam, from the 7th to the 14th of September, under the presidency of Professor Donders. During the session there will be an exhibition of objects connected with medical science.

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Prize Treatise on Diphtheria.—The Empress of Germany has, through Professor Langenbeck, offered a prize for the best treatise on diphtheria that shall be published within a year.

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OBITUARY RECORD.—Died at his country-seat near Toulon, on April 20, of cancer of the stomach, Dr. ADOLPHE GUBLER, Professor of Materia Medica and Therapeutics in the Paris Faculty, aged 58 years.

—— at London, on the 23d of April, of heart disease, CHARLES MURCHISON, M.D., LL.D., F.R.S., aged 53. Dr. Murchison was a graduate of the University of Edinburgh, and physician to St. Thomas's Hospital, and late president of the Pathological Society of London. He was an industrious student, and was the author of numerous contributions to medical literature. He is, however, best known on this side of the Atlantic by his great work on the *Continued Fevers of Great Britain*, a book which will serve for all time as a model of clinical research. He also wrote a valuable work on the *Functional Derangements of the Liver*.

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The association of such distinguished authors as Professors Stillé and Maisch in the composition of a work of this character has excited the strongest interest and the highest expectations in the mind of every physician and pharmacist in the country For once we can truly say that the promise of excellence has been fulfilled to the letter, and the National Dispensatory has come almost perfect from the hands of its makers. The entire work is a most excellent one, and cannot fail to satisfy the purchaser. We can conscientiously recommend it to every student and practitioner of medicine and pharmacy.—*St. Louis Clin. Record*, April, 1879.

The therapeutic part is as rich as would be expected of the author of the most comprehensive work on the subject in our language. The physiological effects of drugs receive due attention, and their influence over disease is stated succinctly. For the task of winnowing the immense accumulation of periodical literature, the experience and matured judgment of Prof. Stillé were eminently fitted. No pharmacist or doctor will repent the purchase of a book which is at once a treasury of facts and the digest of a decision of a high court.—*Louisville Med. News*, March 29, 1879.

This magnificent work has at last arrived, and we are at a loss for words to express our appreciation and to give our readers an idea of it. The subject-matter is brought to date, showing that it has been the unceasing aim of the authors to supply a much needed book, one that will contain all the important facts, and not dwell upon points that are of comparatively little interest to any but a specially interested student While this work, on account of its conciseness, is adapted to the pharmacal student, it is equally adapted to the medical student and practitioner by its well arranged therapeutical index containing about 3750 references, while the materia medica index embraces about 10,400. The physician sees at a glance all medicines that are used for any certain class of disease.—*Chicago Pharmacist and Chemist*, April, 1879.

The very thorough and complete manner in which his (Prof. Maisch's) work is done, being comprehensive without prolixity, robbed by its very pertinence and terseness of all ambiguity, purged of all redundant verbiage and obsolete theories, it stands to-day as a compend of pharmaceutical science—pre-eminent.—*Va. Med. Monthly*, May, 1879.

The reputation of Prof. Stillé is national. What he undertakes to do, he will do, and in the present work we are not disappointed. The National is a complete consecutive volume. The topics are arranged in alphabetical order, afford all the desired information in regard to each drug, its properties, action, therapeutic importance. Each drug has its pharmaceutic preparations and proper doses. In a word, the National Dispensatory is complete, both as a dispensatory and materia medica.—*The Obstet. Gazette*, April, 1875.

The able authors of the National Dispensatory have not only given an exhaustive treatise on the virtues of remedies in general, but have not failed to point out the short-comings of certain fashionable medicines, when, in their judgment, the same have been over-rated In short, the National Dispensatory approaches so near perfection, and the work being *absolutely indispensable* to every enterprising physician, we do not yet precisely understand how any one who expects to keep up with the times can do so without a copy.—*Nat. Med. Review*, April, 1879.

The present Dispensatory is arranged in alphabetical order from the commencement, the recent advances in chemistry are mentioned, and an effort made to include the late novelties in the review of the resources of the physician This is carried out with that sound conservative judgment which characterizes all Prof Stillé's work. The chemical and pharmaceutical sections have, we may suppose, received the special care of Prof Maisch; and as he is *facile princeps* in that branch, nothing can be said of them except in praise.—*Med. and Surg. Reporter*, April 4, 1879.

HENRY C. LEA—Philadelphia.

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VOL. XXXVII. AUGUST, 1879. No. 440.

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CLINICAL LECTURES.

ON URETHRAL STRICTURE.

A Clinical Lecture delivered at the Jefferson College Hospital.

BY JOHN H. BRINTON, M.D.,
Surgeon to the Jefferson College Hospital.

GENTLEMEN: During the last three or four weeks I have brought before you a number of exceedingly interesting cases of urethral stricture, and it seems to me that we may now, with profit, pause and pass in review the phenomena characterizing this affection, and the various procedures adopted for its treatment.

As you are aware, the chief symptom of stricture is an inability or difficulty, to a greater or less extent, in passing water. I say the chief symptom, for, in truth, many other phenomena cluster around this one evidence of disease. Of these, however, the patient may be, and probably is, ignorant; his mind is fixed on the one great fact, that urination is with him a source of anxiety, oftentimes accompanied by distress and pain. He will come to you for relief, and upon your just appreciation of his trouble, and upon the adroitness of your hands, must his welfare depend.

Inability to urinate may depend upon stricture of the urethra and its consequences, or upon affections of the prostate gland or bladder. But it is only with stricture and its results that we are occupied this morning. Stricture is ordi-

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narily divided into the inflammatory, spasmodic, and organic varieties. Of the first two I shall not now speak, but shall confine myself entirely to organic stricture, or stricture as it is usually called. The essential element of organic stricture is an inability on the part of the urethral mucous membrane to be dilated to its normal extent or calibre. In the healthy condition of the canal the mucous lining falls into folds, its surfaces resting in contact; by the passage of an instrument, or upon the flow of the urine, these surfaces are separated, and the calibre of the canal is thus increased or dilated. But when from any inflammatory cause, such as urethritis and gleet, chronic changes and deposits are developed in the mucous or submucous tissues, forbidding the dilation or opening out of the canal, organic stricture is established. One of the first effects of the chronic inflammation, inseparable from gleet, is the early occurrence, at different portions of the urethral tract, of granular conditions. The mucous surface at these points loses its normal smooth appearance and becomes studded with minute granulations analogous to those observed on the eyelids in granular conjunctivitis.

This is the condition described by Desormeaux as granular urethritis, and it is one which I have frequently been able to study with the endoscope. It is more than likely that during this period those changes are set up which eventually develop into stricture. When the protecting epithelial layer of the mucous surface is lost, the irritating urine can act directly upon the walls of the canal, and, as a natural result, the formation of plastic lymph ensues. If this be not absorbed, but increase in quantity so as to involve the entire thickness of the mucous layer, or the submucous tissues as well, stricture would appear to be inevitable. Unfortunately, it would seem that when this mischievous lymph is once poured out, there is often but little tendency to its absorption. On the contrary, its disposition appears to be rather to harden and contract, thus insuring the establishment and continuance of the stricture. Occasionally, the lymph deposit may be very great and may extend beyond the immediate circumference of the urethra, and involve the spongy portion of the penis, giving rise to those intractable nodular strictures we sometimes meet with. Here is a negro patient, in whom the condition is present to a most marked degree. He has frequently contracted gonorrhœa, and is now suffering from severe symptoms of stricture. When I raise up the body of the penis and feel the spongy portion, I find that it is the seat of an enormous induration or callosity, which will demand for its relief a very extensive internal urethrotomy.

To sum up these very brief remarks on the pathology of stricture, I may state that stricture may occur in any part of the urethra, with the exception probably of the prostatic portion. It may vary in degree from the slightest narrowing, elastic or yielding to the presence of the instrument, up to the almost impassable barrier we observe in this negro's case. It may be single or multiple; five, six, seven, or more narrowings being found in the same urethra. It may be elastic or resilient or resisting. It may be exquisitely sensitive, and intolerant of the slightest manipulative attack, or it may be callous, and apparently insensible. It may bleed upon the slightest touch, or it may, on the other hand, be handled with impunity.

In practice the great question, gentlemen, for you to decide is the clinical one of treatment. You have seen how protean is the nature of stricture, and you have, at the hands of my colleagues and myself, witnessed the varying curative procedures we have resorted to.

When a man suffers from stricture and determines upon seeking professional advice, he generally does so under one or other of the following train of circumstances. In the first place, his condition may not be very urgent, he is simply inconvenienced; or, in the second place, it may be urgent; urination may have become difficult, or possibly even retention may be imminent, or may have occurred. Let us take the former case, in which the symptoms are not very urgent or aggravated. The man will tell you he has had a slight stricture for months or years.

Some or all of the usual symptoms of obstruction may be present, but to a slight degree. He has become used to them; they scarcely trouble him, or if they do, it is by their continuance, rather than by their severity. Or he may say that urination is not much more frequent than usual, that he voids his water tolerably well, but that when he is about to pass it, he is conscious of a delay or hesitancy in the appearance of the flow. He is therefore obliged to strain a little more than usual, and his urination is slightly prolonged. In any event, he is somewhat alarmed, he feels a little nervous as to his future, and wishes to be cured. So, from one cause or other, he presents himself at your office for examination.

And here I must beg you to bear in mind that this matter of examination is one of the first importance, and deserves to be fairly studied. Of course the merest tyro can form an idea of the presence of a stricture, but this is not all that is required. The surgeon by his manipulation should learn, not only the site of the obstruction, but also all that it is possible to find out concerning its character. By this I mean its sensitiveness or irritability, its shape, direction, and the tortuosity of the urethral canal at the contracted point. The distance of the stricture from the meatus should also be carefully measured and, if possible, the existence and localities of other points of narrowing, should these be present. Now all of these matters it is important to know, not only in the interests of diagnosis, but also in order to arrive at a just decision as to the treatment proper to each individual case.

I insist, therefore, upon a careful examination, such as may result in developing the true condition of affairs. The proper treatment will then follow as a matter of course, for, as you may infer, the attack must vary with the defence, and the instrument which may be well suited to act upon an annular insensible stricture may be quite out of place if the stricture be tortuous or irritable, or both. In conducting urethral manipulations upon a patient you must see that he be placed in the proper position, and that you yourself are also properly placed. For my own part, I never examine a man in the upright posture. I always make him lie down, either upon a sofa, or, which I greatly prefer, upon a table of sufficient height, not less than thirty or thirty-one inches from the floor. This is a good height, if the surgeon be of medium stature. If the table be lower than this, you will be obliged to bend over your patient. This, in itself, is fatiguing, and if unduly prolonged may interfere with the requisite delicacy and gentleness of touch. Depend upon it, if the surgeon be wearied or if he works at a disadvantage, the patient suffers. So take my advice, and place both your patient and yourself in just those relative positions which are most favorable for the work on hand. Of course, these remarks apply with increased force to those cases in which the highest and most delicate skill is demanded, and especially when these manipulations are prolonged, but I think they are not without bearing in the every-day applications of urethral instruments. The office table which I use for these examinations is of the height I have mentioned, and is provided with diverging slide rests for the feet, somewhat after the gynæcological chairs so much in vogue. You here see just such a table, and you have often, I am sure, noticed how securely the patient rests, how firmly his limbs are supported, and how much easier it is for the surgeon to operate and the patient to endure under these circumstances.

Now, as to your own position. In the great majority of cases the patient rests at full length upon a lounge, or sofa, or table, with his feet drawn up, and his shoulders raised; you may stand upon either side, preferably, I think, upon the left, thus using the instrument with your right hand. For my own part, however, in all really difficult cases of stricture, and in obstinate obstruction dependent upon enlarged prostate, I greatly prefer to place my patient on the broad of his back, and to stand between his knees. In office practice, and with a table or reclining chair furnished with foot-rests, this can readily be done. At a patient's home, you will not have this convenience, but you can always bring the man to the edge of a bed, letting his buttocks rest upon a pillow, and having his feet supported by two chairs and his knees well separated. A pillow or two should be placed under his head and shoulders, so as to elevate his trunk to a proper degree. Each thigh and leg should be wrapped in a separate blanket or shawl. If the patient have on his drawers, let him take out only one leg, say the left, and then only the other will require to be blanketed. The body should be well covered and proper care taken to protect the patient from draughts and currents of air. A patient who is warm, well-protected, and comparatively comfortable, retains his confidence longer, and will submit to a much more prolonged endeavour on the part of his surgeon than one who is chilled, trembling and nervous. In difficult operations, as, for example, in those for aggravated stricture, or for retention of urine, you will do well to take your stand between the patient's knees. By so doing you will be able to manage your instruments to the best advantage, and you will the more readily preserve in your mind the precise relations between the point of the instrument in your hand and its anatomical bearings. But, in ordinary cases, and in every-day practice, it will answer quite well to stand upon the patient's left side, as I have already explained to you.

Next, you will introduce an instrument to examine the urethra, and search for the suspected obstruction, and for this purpose you can employ either a metallic or flexible instrument. I do not think it matters very much which you make use of, provided the point be a rounded one, and not a conical one. As a rule, patients have a greater dread of the metallic than of the flexible instrument, and it is therefore perhaps well to use the flexible one at first. But in this matter of urethral exploration, professional opinion has of late years undergone much change. Formerly it was taught, by no less an authority even than Sir Henry Thompson, I think, that if an instrument, say a flexible one of the calibre of No. 10, English measure, passed easily into the bladder, that there could be no stricture. But more recently the investigations and industry of our countryman, Dr. Otis, have shown that this is not altogether the case. Dr. Otis asserts that instruments of moderate calibre, as those I have mentioned, may pass quite readily into the bladder, and yet a stricture may be present. In other words, that the normal calibre of the urethra may at points be abnormally narrowed, and to such a degree as to check or impede the passage of the urine to a certain extent, and thus, in Dr. Otis's opinion, to develop many of the phenomena of stricture. To these narrowings the term "strictures of large calibre" has been applied, and without being prepared to go quite as far as Dr. Otis does in the matter of incision of these stricturing bands, we must all admit that a most valuable contribution has been made to the subject of urethral pathology. It is evident, too, that in the examination of urethræ suspected of stricture, in the future, we must look more closely than possibly we have hitherto done, and direct our operations accordingly.

I therefore advise you to be very careful in your investigations of the closed urethra. The flexible No. 10 or 12 catheter, well warmed and curved gently down, may be arrested say at two, three, or six inches from the meatus. The existence of an obstruction or stricture is most manifest; this you have learned, and it is an important fact in the history of the case. But you must learn more, you must find out exactly the distance of the stricture from the meatus, its length, and the presence of any lower or more deeply seated obstructions. For this purpose you will resort to the flexible olivary or acorn-ended bougies I show you here, and with which you are already so familiar from their frequent use in this arena. You know from observation how the exact site of one or more stricturing bands or rings may be detected, located, and measured.

Now, let me suppose that we have found and measured accurately a stricture, distant let us say five and a half inches from the meatus, and let us suppose also that this stricture will admit a small sized catheter, thirteen to seventeen of the Charrière scale; that is, from about seven to ten of the English measure. The parts are not very sensitive, and the patient is in good condition. How shall we treat this man? We have three methods to our choice, dilatation in some gradual form; divulsion, or rapid forcible dilation; and incision from within the urethra, or internal urethrotomy as it is called. My answer at once is, by dilatation; failing in this then by internal urethrotomy.

Dilatation, as you are well aware, may be accomplished by one of two plans—it may be either slow or rapid. The former is effected by the daily and continuous use of sounds. Thompson's sounds made of steel, and nickel-plated, which I show you here, are the best—or the parts may be gently dilated by small instruments, flexible or metallic, up to a calibre which will admit the insertion of one or other of the gradual dilating instruments in use. The blades of the latter are then slowly but firmly separated by the screw in the handle, and the walls of the strictured urethra are thus efficiently stretched. This process may be repeated, if necessary, at an interval of a few days, although it is generally required to a very much less extent, and the cure of the stricture may then be completed by the introduction of sounds daily, semi-weekly, and really at longer periods. Before discharging a patient from treatment, I always instruct him in the passage of the sound, and I see that he can do so with certainty and confidence. I then direct him to pass the instrument every week or ten days. The dilating blades I prefer are on the table before you. You have witnessed their action time and again. Here is Thompson's, which will pass through a stricture of No. 11 Charrière's measurement; here is another form of the same instrument in which the blades separate perfectly parallel. Its character is the same as the preceding, and, in consequence of their small size, both of these instruments are eminently suitable for the stretching of tight strictures. I show you now another instrument of which I think most highly, it is the one devised by my colleague, Dr. S. W. Gross. It is larger than those I have first shown you, its diameter corresponding to No. 17 or 18 of the Charrière scale. It is a powerful instrument, and admirably adapted for the stretching of hard, tight strictures. It has moreover one great advantage, and that is a graduated scale in the handle, which tells you while you are turning the screw exactly to what extent the blades of the instrument are separating the strictured walls.

Here, then, gentlemen, you have excellent means for treating a stricture by dilatation, first by bougies, and next by the stretching instruments I have alluded to. Now if from any reason, say irritability of the stricture, excessive or prolonged pain, extreme nervousness on the patient's part forbidding repeated manipulations; or the presence of a stricture so elastic or resilient as always to return on the cessation of manipulation, dilatation fail, or prove unprofitable, what then must be done? In my judgment the time has now been reached at which internal incision, the operation of internal urethrotomy, is not only justified but is urgently called for. I prefer, usually, dilatation in some form to incision of this stricture, but when dilatation fails, incision is pre-eminently the operation. It matters little, I think, which variety of cutting instrument is selected. Here are three of them. Dr. Otis's, Dr. Gross's, and the Charrière combination of Civiale's and Maisonneuve's urethrotomes. The two former cut in a dilated urethra. The latter acts upon the urethra in a partially flaccid condition. You may take your choice. From long habit, I have become accustomed to the Charrière instrument, but you have all witnessed how beautifully the urethrotome of my colleague does its work. Let us suppose we have divided a stricture by internal urethrotomy; what is the after treatment? You have seen me over and over again prosecute it before you in this arena. The division once effected, and before the patient is removed from the table, I introduce the nickel-plated sound, until a sufficient calibre has been attained, let us say No. 27, 28, 29, or 30. I then direct a full dose of opium and quinia, have the man well covered up, put to bed, and do not touch him, or permit him to be touched with an instrument for three or four days. Too much urethral meddling at this time is, I am satisfied, bad: it can do no good, and may do much harm. When the sick man shall have recovered from the shock of the operation, if shock there be, and this I think is more apt to take place when ether is used than when it is not, then I begin the use of my sounds, and instruct my patient in the same manœuvre. If he be expert, he should now be able to preserve the patency of the urethra, and thus render himself the master of his own case in the future, at all events subject only to the occasional surveillance of his surgeon.

I have thus far, gentlemen, spoken to you of strictures which, when first brought before your attention, permit the passage of a small instrument, No. 9, 10, or upwards. Let us now examine those of a more severe character, such, for example, as were present in the men Durrell, Small, Connu, and others. The history of these patients and their brethren may be thus epitomized: First of all, years ago, a neglected gonorrhœa, followed by successive claps, aggravated by exposure, hard living, and possible debaucheries. With time the stricture or strictures gradually became tighter and tighter, the pain on micturition increased, and the whole train of urinary symptoms assumed an irritative character with which the constitution largely sympathized. On examining each man we found stricture of the most determined nature, so tight indeed as to forbid the entrance of all ordinary instruments. In old times, such strictures were called impermeable, impassable strictures; but, as has been justly observed, no stricture can be called impermeable, through which even a drop of water at times can pass. Impermeability is in fact but a relative term, and with the improved instruments at our hands does not exist. The stricture which a few years ago was so difficult to manage, has now become docile to a degree, and this has been brought about in great degree by the introduction of the whalebone filiform bougie and the tunneled catheter.

I do not intend here to enter into the vexed question as to the priority of invention of these, and especially of the latter instruments. I am heartily thankful that we have them all, and to whomsoever their origin is due, we owe our hearty acknowledgments. I have already frequently drawn your attention to these whalebone bougies, and have endeavoured to impress upon you that if you would derive from them their greatest benefit, you must not rest content with such as you find in the shops, but must yourself dress them down as I have shown, until in tenuity they become really capillary in character. How well these answer their purpose, I am sure you know, and I hope that you are ready to agree with me when I say that if these whalebones be properly prepared, there is no stricture (excluding rupture of the urethra, and those of traumatic origin) through which they cannot be passed. Of course, as you already understand, this may not be done at once, and it is scarcely possible to effect it, if other instruments of large calibre have been recently used at the hands of other surgeons. I have already cautioned you in cases of very tight stricture always to begin your operations with these whalebones, and carefully to abstain from the use of large round or blunt-pointed instruments; which can only serve to batter down, as it were, the adjacent tongues or folds of mucous membrane upon the orifice of the stricture, and thus hiding it, cause it for the time to escape the search of the first instrument. Do not forget these matters, but bear always in mind two facts. First, that the whalebone bougies to be of service at all, must be very fine and flexible, not plate drawn, or made with the file, but shaven with a sharp knife, and truly capillary. In the second place, no other instruments on the same day should precede their use. These, as you have seen, succeed when properly inserted and in sufficient number, sooner or later one of your quiverful must strike the orifice of the stricture, and inevitably enter the bladder. The difficulty always is simply one of search. If urine can pass, an orifice undoubtedly exists, and the canal however strictured will always permit the passage of the hair-like whalebone. In treating badly strictured cases you should start with the firm conviction that you must find the opening, and that the instrument must go in. Be patient, and persevering, and you will surely be successful, and be spared the ignoble plea of "spasm."

When once a whalebone bougie has been made to enter the bladder, the victory over the stricture is assured. You have but to pass these tunneled catheters until a calibre of urethra is attained sufficient to place the stricture at your mercy. But here a caution is necessary. The ordinary tunneled catheters, even of smallest size, as usually met with, are too large. You must see that yours of lowest number shall possess no greater calibre than just that which is necessary to slide readily downward along your filiform bougie, and to pass it through the stricture you must employ the proper manœuvre. Thus, slide the instrument along the whalebone until the stricture be reached, and then the whalebone and catheter being grasped together, carry both forward through the stricture by the same motion of the hand. By these means, successive catheters may be passed into the bladder, gradually overcoming and distending the stricture, until the ordinary sounds, dilating instruments, or urethrotomes can be used with advantage.

You may notice, gentlemen, that I have thus far said nothing to you of divulsion, or bursting, or the treatment by Mr. Holt's method. Some time since I practised this procedure extensively, as indeed did many of my surgical friends of this city. Admirably successful as it was in numerous cases, it was however in other instances attended by severe shock. Unfortunately I have had more than one opportunity of observing in post-mortem examination the effect of the instrument upon the urethral mucous membrane. As far as my experience goes, in every instance the mucous membrane, as well as the submucous callous bands, were divided as cleanly as if they had been cut by the blade of the urethrotome. I should, however, state that in all cases which I have known of death following the use of Holt's divulsor, the unfortunate result has occurred in public practice, among patients in the lowest social scale, whose constitutions had been broken down by lives of vice, intemperance, exposure, and debauchery. I have never known a death to occur in private practice from the use of this instrument. I have, nevertheless, come to regard the methods by dilatation in its various forms, combined with internal urethrotomy when necessary, as the preferable modes of treating urethral stricture.

Retention of urine, more or less complete, is one of the gravest accompaniments of urethral stricture. During the last three or four weeks we have received in hospital six of these cases, and you have had the opportunity of witnessing the different treatments resorted to for their relief. In all of the cases the bladder was very full, in fact greatly overdistended; and the agony and distress of the poor sufferers were extreme. This you can readily understand when you consider for a moment how great must be the tension, when the bladder, which ought to hold a pint, or a pint and a half, is gradually and cruelly distended to the capacity of from fifty-five to sixty-five fluid ounces. So great is the stretching, that the muscular coat is entirely paralyzed; it cannot act, and no urine escapes, save the little dribble of overflow, which forces its way past the resisting stricture. You have seen these cases, and I therefore need not now dilate on their sufferings and perilous condition.

What, gentlemen, will you do when called upon to treat such patients hereafter? The warm bath, opiates, and anæsthetics are all very well in their way, excellent adjuncts to your treatment, but much more is required. You cannot turn your back on these cases, and postpone active treatment to a more convenient season. You must do what is necessary to effect their relief at once. And here let me say to you, that you must have confidence in yourselves; you must feel that you are able by some means or other to bring to the patient the relief he stands so sorely in need of. What, then, should your treatment be? First of all, it is well to have the sufferer placed in a warm bath, the heat of which is gradually increased by fresh additions of hot water.

Then, in ten or fifteen minutes, place the patient, if not relieved, upon the table, and have him thoroughly anæsthetized. It may be that the circumstances of the case have not permitted a hot bath. You must then resort to the ether at once. When your patient shall have come fully under the influence of the ether, you will begin your attempt at catheterization This may be usually effected by one of two methods—the use of the whalebone bougies, or the employment of large rounded instruments. I prefer to begin with the former always. It is in operating upon a case of retention that it is so important that the patient should be upon a high table, for then the surgeon can work without being fatigued, and these manipulations are often very prolonged Sooner or later, if you be persistent and adroit, and work in the manner I have taken so much pains to demonstrate to you, you will succeed in inserting a filiform bougie into the bladder. You have seen me so succeed, when I know most of you have regarded the result as almost an hopeless one. But you can succeed, and you will succeed, if only you will make for yourselves such filiforms as I make and employ in the treatment of these cases. You must have patience, and not become discouraged and fly off to other procedures. Be pertinacious, and gentle, and in the end you will accomplish your purpose.

Let us suppose that you have at last passed a fine filiform through the stricture and into the bladder, what is your next endeavour? You may try and pass over it, in the manner I have taught you, a tunneled catheter of the smallest size. Possibly you may succeed; more probably you will fail at your first attempt. In that event I advise you not to continue your efforts in the same direction, but to withdraw the catheter from the urethra, taking care to leave the whalebone filiform in position, and being sure that its minute olivary end projects into the bladder. In a little while you will be rejoiced to find that the urine will pass freely by the side of the whalebone. Here I show you a basin full of urine tinged with blood, which has in this manner been voided from the bladder in a case of very bad retention in this ward since yesterday afternoon; and at our last clinic I made you a similar exhibit. A warm bath now, and a full dose of opium, will accomplish all that can be desired, when once the instrument, no matter how fine, has been carried into the bladder.

You may, gentlemen, perhaps think that I am urgent to weariness on this topic, but the time may arrive when you will require all your professional resources in overcoming an obstinate retention, and I am assured that the procedure I have described to you will then be found very potent for good. At all events, it is the one upon which I mainly rely, and you will take it for what it may be worth, and judge of it by your own clinical experiences hereafter.

HOSPITAL NOTES AND GLEANINGS.

A Case of Antiseptic Ovariotomy in a Syphilitic Patient; Recovery; Remarks.—R. M——, aged forty-four years, stated that she had been married twenty-one years, and had given birth to five children, who had never manifested any signs of constitutional disease. She had never miscarried. Eight years before admission, subsequent to her last confinement, she had a severe attack of rheumatic fever, and twelve months before she noticed the enlargement of the abdomen. The swelling commenced on the right side. She positively stated that she was not aware that she had ever contracted any other disease.

On her admission into the Royal Portsmouth Hospital, under the case of Dr. J. WARD COUSINS, she looked pale, careworn, and emaciated. On the forehead were four fistulous ulcers, discharging offensive pus, associated with extensive caries of the frontal bone. The surrounding skin for some distance was irritable, red, and tender. The voice was thick and husky, and there was chronic laryngeal irritation and cough. The abdomen was much enlarged; two inches below the umbilicus it measured thirty-three inches in circumference, and fourteen inches from the ensiform cartilage to the pubic symphysis. Dulness was well defined, and fluctuation over the right half of the tumour was moderately distinct. During respiration the abdominal walls did not appear to move over the surface of the tumour. On vaginal examination the right side of the pelvic cavity was fuller and more elastic than the left, but no solid substance could be detected, and no fluctuation occurred on external percussion of the abdomen. The uterus was movable; its cavity measured three inches.

On June 4th, 1878, the tumour was tapped with the hope of relieving the dyspnœa and oppression which greatly distressed her, but only three pints and a half of thick brownish fluid, of the consistence of gruel, were withdrawn. Severe abdominal pain and fever for some days followed the operation.

Antiseptic ovariotomy was performed on July 2d. The tumour was multilocular, and weighed eleven pounds. Some extensive omental adhesions were separated, and the bleeding vessels were secured with fine silk ligatures. The pedicle was clamped externally. The day following the operation the temperature stood at 103° and the pulse at 130; but on the 6th all urgent symptoms had subsided; temperature 99°; pulse 90, fairly full, and regular. The wound rapidly healed, and the clamp came off on the tenth day. During her convalescence she suffered from two attacks of erythematous inflammation of the forehead and face, but these attacks, she stated, had frequently occurred during the last three years. The constitutional disturbance was only trifling, and scarcely impeded her recovery. She left the hospital on August 5th. In January, 1879, she was in better health than she had been for years, but the constitutional manifestations of syphilis were unchanged.

Remarks by Dr. Cousins.—The interesting point in the case is especially associated with the constitutional condition of the patient at the time of the operation. She had undoubtedly contracted syphilis (probably since her last pregnancy), and she was labouring under tertiary complications. Her general condition was greatly damaged by the disorder, and the deep character of the taint was manifested by the caries of the frontal bone and the chronic laryngeal mischief. To say the least, at the time of the operation the patient was the subject of a cachexy associated with the remote effects of syphilis, and a risk was present that the shock of a severe surgical proceeding might excite the old disorder into some form of dangerous activity. Her condition, however, appeared to be actually more favourable for interference than any future condition could possibly be. The constitutional powers were, indeed, seriously damaged, and the nutritive and reparative action of the system impaired; still, the immediate danger of her case arose more from the presence of the abdominal tumour than from the syphilitic complication. The result of the operation has given her a fair prospect of living several years, and has placed her in a better condition for struggling with a grave and tedious disease, which in the lapse of time may undergo a favourable modification.

The taint of syphilis, even of the tertiary stage, is not wholly confined to certain tissues and organs. It sends a latent influence throughout the entire organization. The patient looks aged, sallow, and emaciated; and the term "syphilitic cachexy" expresses the deep constitutional changes which have been stamped upon the vitality and nutrition of all the structures. It is an interesting fact that the presence of a specific cachexy does not always retard the healing of recent wounds. In this case the abdominal incision closed rapidly and firmly in a few days. In the peculiar cachexy, too, which attends the last stages of cancer the reparative power of a part may be roused by a wound into remarkable activity. Three years since a patient labouring under carcinoma of the uterus came under my care with strangulated femoral hernia. She was sallow and emaciated by long-standing disease, and had been confined to her bed for weeks with constant uterine hemorrhage. Herniotomy was performed; the wound healed by first intention, and the patient rallied, and lived nearly two years after the operation.—*Lancet*, April 5, 1875.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

The Prevention of the Spread of Yellow Fever.—The National Board of Health recommends the adoption of the following rules and regulations for the prevention of the spread of yellow fever:—

All cars leaving infected places shall be thoroughly cleansed and fumigated with sulphurous acid gas, by burning eighteen ounces of sulphur for every 1000 cubic feet of space, closing up the car tight for six hours prior to date of leaving.

No upholstered car shall be allowed to leave a dangerously infected place.

All baggage shall be thoroughly disinfected at the station before leaving.

At a point not less than five miles, and as near this distance as possible, from the point of departure from a dangerously infected place, there shall be an entire transfer of passengers and baggage to other cars, which cars shall never enter an infected district.

This transfer shall be made in the open air under the supervision of a medical officer, and as far from a habitation as possible; and no person with fever shall be allowed to proceed, but shall return to the point of departure, or be treated in hospital at or near the place of transfer.

The medical officer at the transfer station shall carefully examine the conductor's certificates, and the certificate of each passenger, and fill the blanks appended to them to accord with the results of his examination.

No sleeping-car shall be allowed to leave a dangerously infected place, nor shall any sleeping-car approach nearer such place than the point of transfer. Any passenger car leaving such infected place shall be thoroughly ventilated during its passage to the place of transfer, by having the windows of the cars open during such passage.

In case of suspected infection of a passenger car, or of a sleeping-car, such car, including all the upholstery, cushions, curtains, mattresses, etc., shall be thoroughly disinfected, under the supervision of a medical officer, and shall be exposed to the open air for at least twenty days before being again used.

All freight shall be transferred at a point not exceeding fifty miles from the point of departure, and the cars from which such freight has been transferred shall not proceed further on the road, but shall be returned to the point of departure. The freight cars, after unloading, shall be thoroughly cleansed by scrubbing, fumigation, disinfection, and ventilation.

Mail matter and mail bags should be heated to a temperature of two hundred and fifty degrees Fahrenheit, or should be otherwise disinfected before they are sent from infected places.

At some point not less than fifty miles from the first transfer station, a second complete transfer of passengers and baggage is desirable, and should be provided for by the authorities of the States through which the lines run.

If yellow fever infect a place situated upon a line of railroad, trains of all kinds may be permitted to pass through without stopping, and at a speed of not less than ten miles an hour, provided the National Board of Health has not declared it dangerous to do so, and published through the local health authorities a special rule forbidding it.

At a largely attended meeting of the representatives of the railroad and steamboat interests of the Mississippi valley, held at Memphis on the 2d of July, the above rules and regulations were read separately, discussed, and unanimously approved, and assurance was given of the cordial co-operation of the railroad and steamboat interests in all measures adopted by the National Board of Health in their efforts to prevent the spread of contagious and infectious diseases.

In a circular dated July 12, the National Board of Health recommends that whatever opinions may be held as to the causes of yellow fever and of the recent appearance of that disease in Tennessee and Mississippi, it is best to act as if it were a disease due to a specific particulate cause which is capable of growth and reproduction, transportable, and may be destroyed by exposure to a temperature above 240° Fahrenheit, or by chemical disinfectants of sufficient strength if brought into immediate contact with it.

It is also prudent to assume that the growth and reproduction of this cause is connected with the presence of filth, in the sanitary sense of that word, including decaying organic matters and defective ventilation, as well as of high temperature.

The cases of yellow fever recently observed should be considered as due to causes surviving from last year's epidemic, and not to recent importation from other countries. It follows that there is a liability to the appearance of other cases in places visited by the epidemic of last year, and that there is danger of the spread of the disease to the North and the East.

The Board advises that all cities, towns, and villages be at once made clean, in a sanitary point of view. The first step toward securing this cleanliness is to obtain reliable information as to what parts of the place are clean, and what foul.

The results of a careful sanitary inspection of almost any city or town will show the existence of collections of decaying and offensive matters previously unknown, and which every one will admit should be promptly removed and destroyed.

Such inspections to be of value must be thorough and made by persons competent to recognize foul soils, waters, and air as well as the grosser and more palpable forms of nuisance.

They should also be made by persons who will report fully and frankly the results of their observations without reference to the wishes of persons or corporations. When the whereabouts and the extent of the evil are known the remedy is usually almost self-evident.

The National Board of Health will furnish, upon request, blank forms as a guide for such inspections. — *National Board of Health Bulletin*, June 28 and July 12, 1879.

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New Hampshire State Medical Society.— The eighty-ninth annual meeting of this Society was held at Concord, June 17th and 18th, Dr. Alonzo F. Carr, of Goffstown, President, in the chair. The following officers were chosen for the ensuing year: President, Thomas J. W. Pray, M.D., of Dover; Vice-President, Granville P. Conn, M.D., of Concord; Secretary, Moses W. Russell, M.D., of Concord. The Society adjourned to meet on the third Tuesday in June, 1880.

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Massachusetts Medical Society.—The annual meeting of this Society was held at Boston, June 10th and 11th, Dr. George H. Lyman, of Boston, President, in the chair. The following officers were elected for the ensuing year: President, Dr. Geo. H. Lyman, of Boston; Vice-President, Dr. David P. Smith, of Springfield; Secretary, Dr. F. W. Goss, of Roxbury. The next meeting will be held in Boston on the second Wednesday in June, 1880.

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Rhode Island Medical Society held its sixty-seventh annual meeting at Providence, June 10th, Dr. Edward T. Caswell, presiding. The Trustees of the Fiske fund reported that they had awarded the premium of two hundred dollars for the best essay on the "Artificial Feeding of Infants" to Dr. Oliver C. Wiggin, of Providence, and the premium of two hundred dollars for the best essay on "Cholera Infantum" to Dr. Charles E. Banks, of Portland, Me. The following officers were elected for the ensuing year: President, Dr. E. T. Caswell, of Providence; Vice-Presidents, Drs. George P. Baker, of Providence, and Charles O'Leary, of Providence; Secretary, Dr. W. E. Anthony, of Providence.

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Medical Association of the State of Missouri.—The eighteenth annual meeting of this Society was held at Columbia, Boone Co., May 20th and 21st, under the presidency of Dr. Schauffler, of Kansas City. The following office bearers were elected for the ensuing year: President, Dr. G. M. B. Maughs, of St. Louis: Vice-Presidents, Drs. A. W. McAllister, of Columbia, C. Lester Hall, of Marshall, W. H. Bryant, of Savannah, C. A. Thompson, of Jefferson City, and A. N. Girard, of Shelbina; Secretary, Dr. A. J. Steele, of St. Louis. The next meeting will be held at

Carthage, on the third Tuesday in May, 1880.

Ohio State Medical Society.—The thirty-fourth annual session of this Society was held at Dayton, June 3d, under the presidency of Dr. B. B. Leonard. The following officers were elected for the ensuing year: President, Dr. J. A. Murphy, of Cincinnati; Vice-Presidents, Drs. John Davis, of Dayton, Thomas McEbright, of Akron, J. D. Edwards, of Xenia, and C. A. Kirkley, of Toledo; Secretary, Dr. J. F. Baldwin, of Columbus. The next meeting will be held at Cleveland, on the first Tuesday in June, 1880.

Michigan State Medical Society held its fourteenth annual meeting at Detroit, June 11th and 12th, Dr. Edward Cox, of Battle Creek, President, in the chair. The following officers were elected for the ensuing year: President, Dr. George K. Johnson, of Grand Rapids; Vice-Presidents, Drs. J. T. Thomas, of Battle City; D. O. Farrand, of Detroit; W. F. Breakey, of Ann Arbor; E. S. Snow, of Dearborn. The Society adjourned to meet in Grand Rapids on the second Wednesday of May, 1880.

Colorado Medical Association convened at Colorado Springs in ninth annual session, May 20th, 1879, Dr. A. Stedman, of Denver, presiding. The election for officers for the ensuing year resulted as follows: President, Dr. B. P. Anderson, of Colorado Springs; Vice-Presidents, Drs. H. A. Lemen, of Denver, M. Beshoar, of Trinidad, and E. W. Cushing, of Trinidad; Secretary, C. C. Lathrop, of Denver. The next meeting will be held at Denver.

American Neurological Association.—The fifth annual meeting of this Society was held at New York, June 18th, 19th, and 20th, Dr. F. T. Miles, of Baltimore, President, in the chair. A number of valuable papers were read, and the following officers were elected for the ensuing year: President, F. T. Miles, M.D., of Baltimore; Vice-President, R. T. Edes, M.D., of Boston; Secretary, E. C. Seguin, M.D., of New York. The Association adjourned to meet in New York on the third Wednesday in June, 1880.

FOREIGN INTELLIGENCE.

Winckel's Disease.—At the Congress of Children's Doctors recently held in Berlin, Professor Winckel, the Director of the Royal Lying-in Institution of Dresden, communicated some observations which he had made upon an apparently novel children's disease occurring in that institution. An epidemic of it broke out towards the end of March last. Of twenty-three children attacked, nineteen, or 82 per cent. died, and the average duration of illness in the fatal cases was thirty-two hours. The illness began with a sudden stupefaction of the patients; the respiration became hoarse, accompanied with groaning, and occasional foaming at the mouth. One remarkable feature was a change in the blood. Dr. Winckel made incisions in some cases, but it was only by using pressure that blood could be extracted. It was then found to resemble a thick brown-black fluid of the consistency of a syrup. The body became flaccid, the liver much swollen; eventually convulsions supervened, during one of which the child expired. The President of the Congress, Privy Councillor Dr. Gerhardt, of Würzburg, suggested that this new disorder should be designated "Winckel's disease."—*Med. Times and Gazette*, May 17, 1879.

Dressmakers' Fingers. — The *Journal d'Hygiène* draws attention to a deformity, occurring in tailors and dressmakers, which has not yet been described. It is a contraction and ankylosis of the two upper phalanges of the fourth and fifth fingers of the right hand. This deformity is due to the position of the hand in sewing, when the first three fingers of the right hand are always active, while the other two are doubled up in the hollow of the hand, where they remain immovable. After a certain time, the tendons and flexors begin to contract, and adhesions and ankylosis are soon formed. The author advises prophylactic treatment: the hand must be extended on a board during the night, and the patient be made to use all the fingers in gymnastic movements, and in working in the house and garden.—*British Med. Journal*, April 26, 1879.

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Eczematous Eruptions of Stumps.—M. Duplay (*Gaz. des Hôp.*, June 28th) observed, at the Société de Chirurgie, that he had met with a condition of the stump after amputation, in two of his patients, which has not been noticed by authors. In both there appeared on the stump successive crops of eruptions of eczema, presenting all the characteristics and mode of evolution of ordinary eczema. During six months the eruptions resisted all modes of treatment, and disappeared at last by the sole power of nature. Neither of these patients had suffered from eczema before. M. Duplay believes that the eruption in these cases is analogous to those obstinate eruptions which occur on ill-nourished limbs, due to a trophic cause. He thinks that there is neuritis of the extremities of the nerves of the stumps, which is the point of departure of these successive crops of eruption. The eruption is of no consequence in itself, but it delays the wearing of an artificial limb for some months.—*Med. Times and Gazette*, July 5, 1879.

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The Statistics of Whooping-cough.—Some very interesting details concerning the occurrence, etc., of whooping-cough were communicated by Unruh at the Naturforscherversammlung in Dresden. In the outdoor department of the Hospital for Children in Dresden, 1952 cases of whooping-cough came under treatment during forty-three years. The majority of these cases occurred in the third quarter of the year, and especially in August; the minority in the second, in May. A greater predisposition to this affection seems to exist in female children than in male. The greater number of cases received were between the ages of one and four; the tendency to the affection seeming to increase with the years, thus out of 1000 infants in their first year, 35 were attacked with whooping-cough, and out of 1000 children who had reached their fourth year, 99 had whooping-cough. The affection seldom occurred twice in the same individual, but abortive forms were often met with; these, however, were mostly confined to older children, who may or may not have had the cough. One hundred and thirty children died of whooping-cough, which was equal to 6.6 per cent., or 4.3 per cent. of the general mortality. Of those who had died, 67 (52 per cent.) were in their first year.—*British Med. Journal*, June 7, 1879.

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Strange Course of a Bullet.—The *Presse Méd. Belge* (June 22) exhibits the following account of a case reported by Dr. Aguilar in the *Annales de la Associacion Médico Argentino:* A young man received a ball from a revolver applied close to his chest, which entered it opposite the seventh rib on the right side, and ten centimetres from the median line. Hepato-peritonitis immediately followed, which was cured by leeching and mercurials. The state of the wound continued satisfactory, but the patient complained of very severe pain in the lumbar region, while the discharge of urine, which was at first bloody and then purulent, revealed the existence of a renal lesion. Some time afterwards the urine became clear, and the lumbar pains disappeared. Still, it could not be determined where the ball had lodged, when one day the patient was seized with complete obstruction to the passage of urine, and the catheter came in contact with the ball in the urethra. It was extracted by means of a forceps, measured seven millimetres in diameter, and was covered with incrustations. The ball had, during ten months, pursued its course through the economy, coming in contact with important viscera like the liver and kidney, distending the corresponding ureter, descending into the bladder, and entering the urethra.—*Med. Times and Gazette*, July 5, 1877.

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The Diphtheritic Poison.—A singular instance of the vitality of the poison of diphtheria is reported in the *Vratschebnyia Vedomosti.* A gentleman in the south of Russia had, four years ago, lost a boy from diphtheria. A family vault having recently been constructed, the coffin of the boy was transferred thither. Before it was lowered down into the vault, the father wished to look at the body, having entertained a suspicion that the child had been buried alive. An opening was accordingly made in the lid of the coffin, the whole family, including five children, looking on. The next day all the children were ill with diphtheria, and one of them has since died.—*British Med. Journal,* June 7, 1879.

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M. Koeberlé's Ovariotomies.—M. KOEBERLÉ (*Gaz. des Hôp.*, June 21) communicated to the Strasburg Medical Society the statistics of his recent ovariotomies. In 1878 he practised seventeen with only one fatal result. Besides these he had four other gastrotomies, viz., extirpation of a fibro-cystic tumour from the broad ligament, two extirpations of fibrous tumours of the uterus, and an exploratory incision in a case of hæmatocele followed by chronic peritonitis, the hæmatocele recurring six months afterwards, and being again treated successfully by exploratory puncture. Of these four cases only one proved fatal. During the last four years M. Koeberlé has practised 100 ovariotomies with eighty-nine recoveries and eleven deaths. He ascribes some influence on the results to his practice of cleansing the peritoneal cavity with carbolized water.—*Med. Times and Gazette,* July 5, 1879.

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Poisoning by Carbolic Acid.—A case of acute poisoning with carbolic acid through an enema is recorded by Dr. PRAETORIUS in the *Berliner Klinische Wochenschrift,* April 14th, 1879. The patient, a delicate lady aged 45, had been suffering for several weeks from an obstinate attack of diarrhœa, which could not be stopped by the usual agents, and threatened to undermine the patient's strength. The author prescribed an enema of a one per cent. solution of carbolic acid, of which a quarter of a *litre* was mixed with one-third of a *litre* of warm water. Hardly had one-third of this enema been injected, when the patient began to complain of singing in the ears, giddiness, and weakness, and collapsed. The enema was of course immediately suspended, and the patient told to void her bowels. This was done; but she remained in a collapsed state till the bowels had been washed out with warm water, when she gradually recovered; but it was not till two hours later that the disagreeable symptoms disappeared. The diarrhœa, however, had been stopped by the carbolic acid.—*British Med. Journal,* May 17, 1879.

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Death from Chloroform.—A death from chloroform recently occurred at Toronto. The patient had received an injury resulting in dislocation of the ankle-joint, accompanied with fracture of the lower end of the tibia. Chloroform was administered to facilitate reduction, and while the attendants were in the act of adjusting the parts, stertorous breathing was observed, and almost immediately afterwards respiration entirely ceased, and could not be restored. No organic lesion was discoverable at the *post-mortem* to account for the sudden death. — *Canada Lancet,* June, 1879.

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A New Elastic Suture.—The following elastic suture is recommended by Dr. VOGEL for closing a gaping superficial wound, and for drawing the edges of the latter together. Wide strips of sticking-plaster are placed on both sides of the wound, from one to two inches from the edge. Several small holes are then made in that portion of the strips which is near the edge of the wound, and small-sized studs are placed into the openings. A narrow India-rubber band is then laid across the neck of two opposite studs, slightly tightened, and fastened. This new suture is said to have answered very well in cases where the metallic suture either caused suppuration or could not be applied because the edges of the wound were too far distant.—*British Med. Journ.,* June 21, 1879.

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Suspended Animation.—The nitrite of amyl being a powerful agent in quickening the heart-beat, a few drops of this drug have a powerful influence in restoring the functions of the heart in cases of drowning, hanging, or fainting. It is suggested, therefore, that it should always be used whenever attempts are being made to restore to life an individual apparently dead, or when it is desirable to settle the question whether a person is really dead or not. The dreadful thought of being buried alive has haunted the human race since its earliest days, and the discovery of some means by which this risk could be, if not evaded, at least greatly diminished, would prove an ineffable boon to mankind. Dr. T. Lauder Brunton, to whom we have referred this suggestion, considers it to be a good one. He adds that in ascertaining death the nitrite of amyl might be used along with the cord-test, of tying a cord round the finger. If the circulation have entirely stopped, the part beyond the ligature never becomes any thicker; but if the circulation continue, however slowly, the finger-tip beyond the ligature will sooner or later begin to swell.—*British Med. Journal*, June 7, 1869.

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A New Method for Cupping Extempore.—The following practical advice is published in the number for December, 1878, of *Il Morgagni.* Take a piece of common paper of the size of the opening of the cupping glass and dip it into warm water before applying it. The paper being damp, the skin is kept cool, and prevents by the evaporation of the water the too extensive spreading of the vacuum. If the same piece of paper be used twice, it must be dipped in water before the second application. As far as the cupping-glasses are concerned, a large number of household articles which can be had everywhere, such as tumblers, jam-pots, etc., may take their place if the paper be applied to them in the way we have described. Half-a-dozen similar recipients, which are from three to five inches deep and wide, if applied at once, and the vacuum renewed every two or three minutes, will in about a quarter of an hour produce a most prodigious effect.—*London Med. Record*, May 15, 1879.

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The Electric Light. — Prof. COHN, of Breslau, has been lately making experiments with the electric light on the eyes of a number of persons for the purpose of testing its influence on visual perception and the sensation of colour. He has found that letters, spots, and colours, are perceived at a much greater distance through the medium of electric light than by day or gaslight. The sensation of yellow was increased sixtyfold compared to daylight; of red, sixfold; and of green and blue, about twofold. Eyes that could only with difficulty perceive and distinguish colours by daylight or gaslight were much aided by the electric light, and the visual perception was also much strengthened. Professor Cohn concludes from this fact that electric light would prove exceedingly useful in places where it is desirable that signals should be seen at a great distance. The engine used was Gramme's electro-magnetic apparatus, which rotates six hundred times in a minute.—*British Med. Journal*, May 17, 1879.

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The Paris Faculty of Medicine.—M. Hayem has just been elected to the chair of Therapeutics, made vacant by the death of Professor Gubler.

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OBITUARY RECORD.—At Paris, on the 29th of May, at the advanced age of 85 years, PIERRE ADOLPHE PIORRY, the distinguished author of *Traité de la Percussion Médiate*, to which was awarded, by the Academy of Sciences, the Prix Montyon in 1828. M. Piorry was for many years Physician to the Hôtel Dieu, and was appointed Clinical Professor in 1840. He was also officer of the Legion of Honour.

—At Paris, on the 7th of June, of angina pectoris, WILLIAM TILBURY FOX, M.D., aged 43 years. Dr. Fox is best known in this country by his excellent *Treatise on Skin Diseases*, which has passed through three editions, and at the time of his death he was engaged in revising the work for a fourth. He was an industrious writer, a good teacher and lecturer, and possessed one of the most lucrative office practices in London. He has been long regarded as one of the highest authorities on dermatology in Great Britain.

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CLINICAL LECTURES.

ON ACUTE INFECTIOUS DISEASE.

A Clinical Lecture delivered at the Good Samaritan Hospital, Cincinnati.

BY JAMES T. WHITTAKER, M.D.,
Professor of Theory and Practice of Medicine, Medical College of Ohio; Lecturer on Clinical Medicine at the Good Samaritan Hospital.

GENTLEMEN: When we last met we had before us a typical case of typhoid fever in the height of the disease. We saw displayed, one by one, the signs which characterize the affection, and which, in group, put upon any case of it the stamp of individuality. We have next to discuss the most interesting question connected with its history, viz., its cause. No knowledge satisfies short of the cause, for, as Bacon has said, "*Vere scire est per causas scire.*"

When we come to study the cause of typhoid fever, we confront, at once, the cause of all acute infectious diseases, of which this malady, pre-eminently, is one. While each one of these diseases has individual points of difference, they have all many more points in common, both as regards the symptoms they induce and the lesions they present. If we look, for instance, at yellow fever, the prevalence of which at the present time intensifies our interest in this subject,—a disease which would seem, on account of its localization, to stand apart from the rest,—

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le souvenir d'une tombe et d'un renommé lugubre"

we discover nothing especially secret and peculiar, nothing which might confer upon those most familiar with it special skill in its management or relief; for the initial chill (when present), the intense frontal and lumbar pain, the fever and gastric disturbance, belong to all the exanthematous diseases. Albuminuria occurs in every high fever which markedly lowers capillary tone. Vomiting of disorganized blood (the ominous black vomit) is a characteristic also of typhus, and bad cases of typhoid fevers, hemorrhagic smallpox, and malarial remittents. The distinct and deceptive remission of all the symptoms, the pathognomonic bronzed or mahogany colouration of the skin and mucous membranes, alike distinguishes icterus gravis, some varieties of septicæmia, and chronic malarial poisoning.

Moreover, yellow fever has no discoverable pathological lesion absolutely peculiar to itself. The hematogenous icterus and ecchymosis of the skin, the hemorrhagic erosions of the stomach, with its bloody contents, the anæmic, mostly acutely fatty liver, the hyperæmic and blocked-up kidneys, with, in *foudroyante* and protracted cases, the nearly or quite empty bladder, the granular and fatty degeneration of the muscles, the general catarrh of the mucosæ everywhere—what are all these conditions but signs common to every acute toxicæmia?

We cannot, therefore, study intelligently the etiology of any one of these diseases without a preliminary survey of the entire field.

I do not need to say to you that no subject in medicine is more worthy of our time. The occurrence of an epidemic of acute infectious disease strikes terror as no other calamity or casualty of nature, for the simple reason that no one is so universal or wide-spread in its reach. Those of us who have been eye-witnesses of the devastations of cholera and yellow fever need no reference to the epidemics of the middle ages for full appreciation of the horrors of a plague. Even as we speak there threatens to be left of one of the most populous cities of our Valley, now nearly deserted of its inhabitants, what was left of its namesake of old, merely "a tomb and a shadowy name."

A vast number of facts have been accumulated about these mysterious infectious diseases, many errors have been corrected, many suspicions dispelled or confirmed, until we can almost say that we possess as much definite information regarding the cause of acute infectious disease as regarding the ultimate essence of any other natural phenomena.

This class of diseases, a specimen of one of which has so lately occupied our attention, is especially characterized by more or less rapid dissemination, by intensity or virulence of manifestation, and by comparative shortness of duration. With these characteristics this class of diseases is appropriately grouped under the title of the Acute Infectious Diseases.

The course and conduct of these diseases in the body resemble, to some extent, the action of poisons; hence they are often called blood-poisoning, or septic diseases.

The poison, whatever its nature, once introduced, in however small quantity, into the blood, so swiftly induces manifestations of disease in the whole body, as to resemble the action of a yeast or ferment, a little of which "leaveneth the whole lump," and hence these diseases are also called Zymotic Diseases.

Finally, because these diseases, under the unfavourable hygienic conditions which still surround us, are able to spread over whole sections of country, over whole countries, indeed, unless checked by natural causes, over the whole globe, they constitute what are known everywhere as the Epidemic or Pandemic Diseases.

Types of these diseases are Asiatic cholera, smallpox, chicken-pox, measles, scarlet fever, typhus and typhoid fevers, yellow fever, and diphtheria. In the very forefront of the acute infectious diseases stands, or stood—for our improved sanitary conditions, faulty as they still are, have prevented its spread in modern times—that most terrible of all scourges to man, the plague. At the extreme opposite end of the list, we may read mumps, whooping-cough, and influenza (a marked sample of which, the "epizootic" of 1873, confined nearly every horse of this country to his stall for several days); and along the column at different places, erysipelas, child-bed fever, and dysentery when epidemic, as in ships, hospitals, and camps; pyæmia and septicæmia; with vaccinia, hydrophobia, malignant pustule, etc., as poisons communicated from lower animals to man, and the cattle plague as a typical example of this class of affections in the lower animals themselves.

The characteristic feature of all these diseases is infection. It matters not that they are not all propagated by immediate, direct, or personal contact. In some diseases, the infectious element is fixed close to the body, as in cow-pox and syphilis. These are diseases never propagated by the air, though great stress was put upon the telluric origin of syphilis by a priest who wrote one of the earliest accounts of the disease, as it manifested itself in his own person. In other diseases, smallpox, measles, scarlet fever, the poison is eminently volatile, and is thus disseminated by the air. In still other cases, as in typhoid fever, dysentery and cholera, it is the dejections which chiefly convey the contagium to finally infect the soil and through the soil or sewage canals, by filtration to even great distance, the drinking waters of our wells and cisterns and running streams. To breathe infected air or drink infected water, quite distant from the focus of infection, suffices to engender cholera, dysentery, or typhoid fever, while the contagion of syphilis, and probably diphtheria, must be lodged upon the mucous membranes; and vaccinia, hydrophobia, malignant pustule, the virus from venomous animals, to produce infection, must be inoculated into the very blood itself.

The mode of infection has thus been pretty accurately determined for each of the acute infectious diseases.

Another fact of equal value is the recognition of the specificity of these diseases. Each one of these diseases is known to reproduce itself alone. Measles begets measles, smallpox begets smallpox, cholera begets cholera. Figs would be born of thorns or grapes of thistles as soon as cholera of smallpox, or diphtheria of typhoid fever. The introduction into the blood of the specific cause begets the specific disease.

From this law has been deduced still another fact inestimable in its value: and that is that the spontaneous generation of any one of these diseases is impossible and unknown. Nowhere now is there any question of autochthonous genesis of infectious disease. Everywhere is recognized a house where the disease is indigenous, and a route along which it is spread. The mouths of the Ganges and Brahmaputra are the centres of cholera, lower Egypt of the plague, the Antilles of yellow fever, Ireland of typhus. So far as these diseases are concerned, whose course can be most distinctly traced—cholera and yellow fever, for instance—the line of infection, when accurately pursued, is always found to correspond with the line of transportation by water or rail. The increased velocity of travel in our day, with the correspondingly increased swiftness of the transportation of disease, forms the embarrassing element in tracing the course of disease to its original seat. A week and two days may now suffice to introduce from Europe to our whole country a sweeping epidemic of cholera, and, under favouring conditions, but a few days are required to carry yellow fever from New Orleans to New York. Thus the advanced knowledge of sanitary science in our day, to which we may chiefly ascribe our comparative exemption from the devastating epidemics of ancient times, is counteracted to some extent by the increased facilities for transportation of disease to new centres, the absence of which alone saved the human race in the middle ages from almost utter extinction.

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Smallpox first showed itself in Germany in 1493, an importation from the Netherlands, but it was not until 1527 that it was transported to our country, making its first appearance in Mexico, slaughtering myriads, and then gradually extending over the whole of North America. Scarlet fever, which was first seen in our country in 1735, reached Iceland in 1827, South America in 1829, Greenland in

1847, and Australia in 1848. Measles has not yet been carried to Australia. Cerebro-spinal meningitis, in every respect the most irregular of all epidemic diseases, first fell upon our country in 1806. The ocean was for all time an impassable barrier to cholera, the most wide spread and fatal of all the acute infectious diseases, until it was directly conveyed across in the memorable year of 1832.

The last case of measles in the Faroe islands occurred in 1781. The disease then died out and was almost forgotten, when, in 1846, an individual sick with it came ashore. The inhabitants at that time numbered 7782. Of these, over 6000 fell sick with the measles, and the 1500 that escaped owed their safety to rigid quarantine. On the affected islands, the attack was nearly universal, only the very aged, who had suffered with the disease during and previous to 1781 were spared.

No point in prophylaxis could be of greater value than the recognition of the exclusively parental birth of acute infectious disease.

The close observation of a long series of years has already put us in possession, moreover, of most of the data in the natural history of each of these diseases Thus we have learned first that manifest attack does not follow immediately upon exposure to the disease. There lapses first a period during which the disease lies latent in the body, hatching as it were, the so-called period of incubation. In some cases the length of this period may be determined to a day, by the experiment of inoculation. Thus, the incubation period of vaccinia is 3 days, of smallpox after inoculation 2 days, without inoculation 12–13 days, of scarlet fever 4–7 days, of typhus 7–14 days, of typhoid fever 12–16 days, of measles 10 days, of intermittent fever 1–14 days, of syphilis 2–4 weeks, of the plague 2–7 days, of cholera 2–3 days, of yellow fever 2–9 days, of hydrophobia 3–60 days.

Then supervene the various stages characteristic of each disease, each stage, of more or less definite duration, marking off a definite phase in the course of each disease. We know, again, what are the infecting structures, what is the period of greatest infection, and what is the duration of infection, for each disease.

Lastly, the proof accumulates day by day that all or nearly all the acute infectious diseases are caused by microscopic, or ultra-microscopic parasites, endowed with marvellous powers of reproduction. "From a single germ of the saccharomyces cerevisiæ, the well-known alcoholic ferment, 100 tons of yeast, containing possibly 50 milliards cells, have been generated in a single day in some of our largest breweries." A single drop of fluid containing the bacteria of *milz brand* introduced into the blood of the largest ox, multiplies its poison to such almost incredible degree as to kill the animal in 24–36 hours. In this disease, in relapsing fever, charbon, and septicæmia, the kind and conduct of infecting parasites have been as clearly demonstrated and described as in scabies and trichinosis.

But these parasites or germs do not always multiply in the blood or in the body; hence, not all acute infectious diseases are contagious. Smallpox gives off its contagion from its eruption in greatest virulence just before the vesicle becomes a pustule, in the exhalations from the skin, and in the blood, from which even the placenta does not filter it off. In measles, the disease may be inoculated with the blood, the tears, and the sputum. Scarlet fever infection is in the exhalations from the skin and lungs, and that of typhus irradiates in every direction from every surface and secretion. These are eminently the contagious diseases. In the case of others, yellow fever, malarial fevers, the poison is in no sense entogenous, the germs productive of the disease do not multiply in the blood, nor migrate from it to others about the infected individual. Local colonization, universal dissemination marks the history of the purely contagious diseases; colonization and chemical change characterize those which remain simply infectious.

Gentlemen, we have no time to speak now of the easy solution of all the problems offered by the germ genesis of the acute infectious disease. I shall simply call your attention to an explanation it permits of the so-called sporadic cases of disease where the closest search has failed to reveal a primal cause. I venture it only as a possible explanation, because fortunately most of the poisons of disease are known to hug the ground, to be dissolved in the subsoil water, or at most to creep (when not carried) at almost snail's pace along the surface of the earth. But an ascending column of air, laden with the poison, might be wafted off to very distant seats. That this offered explanation is no mere conception of fancy, is shown by the abundant records of the fall of dust, mostly infusoria, upon vessels far out (1000–1600 miles) at sea. Such clouds of dust have even compelled vessels to put ashore. Mr. Darwin, in his Voyage, says: "In some dust which was collected on a vessel 300 miles from the land, I was much surprised to find particles of stone above the thousandth of an inch square, mixed with finer matter," and adds, "After this fact one need not be surprised at the diffusion of the far lighter and smaller sporules of cryptogamic plants."

Gentlemen, need we be surprised at the occasional occurrence of a sporadic case, at the distant dissemination of acute infectious disease dependent upon germs, when a single bacterium weighs only 0.00000000157, not the millionth part of a milligramme?

The recognition of the fact that these diseases are never spontaneous in development, but that their germs are always somewhere in lurk, would protect us in great measure from invasion, or if invaded, would restrict their dissemination to the narrowest possible limits. Pure water, pure air, and absolute cleanliness, disinfection, rigid and relentless quarantine, and, in proper cases, isolation of the sick, then suggest themselves at once.

In accepting the germ theory as the cause of infectious disease, we have at least a tangible material foe against which to shoot a lance. We are not simply fighting air, comets or eclipses, or supernatural dragons. We are relieved, at once, in therapy from the dreadful nightmare of empiricism.

Our government has at last been awakened to the necessity of a National Board of Health, which gives fair promise already of much good. What is most needed at the present time is the appointment of scientific epidemiologists by the different States, *in loco morbi*, at salaries sufficient to relieve them from the time-consuming necessities of practice. A small fraction of the donations so benevolently contributed during the calamities entailed by epidemics, would probably secure such disclosures concerning the cause, prevention, and cure of infectious disease as would effectually efface them. Whether these disclosures would be the discovery of antidotes like quinia for malaria, or mercury for syphilis; or preventives, like vaccinia, for the smallpox; or conditions which mitigate the dangers, like refrigeration, charbon; it is impossible as yet to say. But it is perfectly safe, with our present knowledge, to predict the speedy extinction of many infectious diseases, the existence of which, at the present time, is a disgrace to medical science and a satire upon civilization.

HOSPITAL NOTES AND GLEANINGS.

Popliteal Aneurism; Preparatory Treatment; Compression; Cure; Remarks — This patient, a man, fifty-seven years of age, was admitted into the London Hospital, under the care of Mr. JONATHAN HUTCHINSON, in December last, with an aneurism in the right popliteal space. He was discharged about the middle of April as "cured," and presented himself a month later, according to instructions, in order that it might be seen whether the cure was permanent and complete. On examination there was found in the popliteal space a trace of the old tumour, but it was very small and without the least sign of even the feeblest pulsation. Pulsation, however, was to be felt in the posterior tibial artery at the ankle, although not so distinctly as on the unaffected side. The case might, therefore, be considered one of perfect cure.

Remarks.—With regard to the tumour itself there was nothing especial to note; it was a typical aneurism in every respect. The patient was a healthy, well developed man of temperate habits, with no history of syphilis and no explanation to offer for the appearance of the tumour, except the frequent and often forcible movements to which his leg would be subjected in following his employment as a carpenter. The aneurism was noticed about four weeks before admission, and was somewhat rapidly increasing in size.

To the treatment, however, of the case special attention should be drawn. Before any active measures for the cure of this aneurism were employed, the patient was subjected to the following preliminary treatment, which had previously been carried out in three cases with uniform success. 1st. He was kept in bed in a state of absolute rest. 2d. His diet was limited as far as possible to solid food, a minimum of liquids only being allowed. The patient, having these instructions before him, and possessed with an intelligent desire to carry them out, managed to subsist on ten ounces of fluid per diem, or one pint in forty-eight hours. 3d. Iodide of potassium was administered.

The perfect rest was of importance in so far as it acted by decreasing the arterial tension of the part and by preventing the aneurismal sac from being exposed to varying degrees of pressure. A diet composed as far as possible of solid foods, with but little liquid nourishment, aided considerably in increasing the fibrine of the blood, and so most favourably prepared the patient for the final and actual cure of the aneurism. The iodide of potassium was administered on account of the power it is presumed to possess of aiding the same process—viz., the increase of the blood fibrine. This action is, however, at present theoretical. This preparatory treatment was pursued for fourteen days. The only visible effect noticed was that the tumour, instead of continuing rapidly to increase, ceased at least to grow, and in fact diminished half an inch in circumference.

At the end of fourteen days the patient was anæsthetized, and Esmarch's elastic bandage and rubber band were applied to the limb. The bandage being removed, the band was kept on for one hour, the patient being under chloroform during that time. The limb was carefully watched during the process, and care was taken to prevent undue loss of temperature. Before the band was removed a number of dressers were ready at once to commence digital compression of the femoral artery in Scarpa's triangle. On the band being removed it was evident that the tumour still pulsated, but much less energetically than before. When digital compression had been applied for four hours all pulsation had entirely ceased in the tumour, but, as a matter of security, the pressure was continued for four hours longer. In a fortnight's time the patient left his bed, no trace of pulsation having been noticed since the day of the compression.

Of the two other cases referred to as having been subjected to this treatment, it may be remarked that in one the pulsation was found to have entirely ceased on the removal of Esmarch's band, while the other case was almost an exact counterpart of the present one. In both cases the cure was sound and permanent.

There are few, very few, cases of aneurism that cannot be cured by digital compression, if properly and intelligently applied, and presuming that compression be anatomically possible; and it is highly probable that that mode of treatment is much assisted by the preliminary procedure above indicated. Digital compression certainly requires a staff of good assistants, and is irksome to the patient; but it is nothing more than irksome; it is a simple and safe mode of cure, and should always have a most thorough trial before any more serious procedure is entertained. —*Lancet*, July 5, 1879.

Intra-Uterine Fibroid Tumours of Uterus, Sessile and Pedicellated, as Causes of Uterine Hemorrhage; Treatment for their Removal.—Fanny R——, aged forty-eight, married, was admitted into Middlesex Hospital, under the care of Dr. Hall Davis, April 30th, 1879, for uterine hemorrhage. It was found to be dependent on an intra-uterine tumour, elevating the fundus nearly to the navel. She had had four labours at full term, the last ten years ago. She had not had any miscarriage. The hemorrhages had been of three years' duration, but most profuse at her menstrual periods.

On admission, the patient had undergone the ordinary styptic treatment for hemorrhage without permanent benefit. She was very exhausted and extremely anæmic; her lower extremities were œdematous, but there was no albumen in the urine, sp. gr. 1014. As she was not then losing blood, it was thought advisable, in view of operative treatment under more favourable circumstances, to rally the patient's strength by tonic treatment.

May 13. That object having been fulfilled, and no hemorrhage of consequence having recurred in the interim, the connections of the intra-uterine tumour were examined to-day. The depth of the uterine cavity, measured by the sound passed to the fundus, was found to be four inches and a half. Part of the tumour occupied the cervical canal, and was adherent to the cervix for three-fourths of its circumference.

The patient was now placed under anæsthesia, commencing with chloroform, afterwards carrying it on with ether. Dr. Davis then detached with the finger the adhesions to the interior of the neck of the uterus upwards, till the rest of the growth, as high as could be reached, appeared free. He then passed up the loop of a wire-rope écraseur over the tumour till he supposed its advance was stopped by an adhesion. His next intention was at once to amputate the growth, but, the process being tedious, he decided, after he had partly crushed through it, to endeavour to remove the tumour by a combination of torsion and extractive efforts. In this way the remaining not very firm adhesions were broken across, and the tumour, by the écraseur purchase, was brought gradually through the os uteri and vagina. It exhibited on its outer surface a cast of the concave interior surface of the uterine cavity. It had been adherent to the fundus and upper part of the body of the uterus by loose tissue without a pedicle. As a safeguard against hemorrhage, the uterus was swabbed out with a sponge saturated in a solution of perchloride of iron, 1 in 4. A suppository of one-third of a grain of morphia was administered in the course of the evening.

No severe symptoms followed the operation, there has been no return of hemorrhage, and the patient is now (June 3d) rapidly gaining strength. She has already lost much of her pallor, and is able to sit up for a short time daily. She is taking tonic medicines and plenty of good nourishment. The weight of the tumour was five ounces, its length four and a half inches, its greatest circumference six and a half inches. Its structure was that of fibroid tissue, closely resembling that of the plain nucleated muscular fibre of the uterus, but not containing any of the cells characteristic of carcinomatous growth.

Dr. Davis referred, in the course of his clinical remarks, to another case of an intra-uterine fibroid tumour, of similar structure to the above, which he had removed in November, 1859, also by torsion combined with extractive efforts, preceded by preparatory separation of the more accessible adhesions. The lady the subject of it was a widow fifty-one years of age. In her case the tumour, which on removal weighed upwards of five pounds, had interfered mechanically with the function of the bladder, and had been the cause of repeated, profuse, and exhausting floodings. The growth was in the above manner gradually drawn out of the uterus, being detached at the same time from the uppermost adhesions to the fundus of the uterus, to which it was not pedicellated. The left hand grasping the upper half of the tumour, and the vulsellum forceps carefully guided and applied to its lower half, were the means of purchase employed in removing the tumour. The patient made a rapid recovery, and returned to her country home within three weeks after the operation. She has now, after nearly twenty years of a prolonged and active life, had no return of uterine disease.—*Lancet*, July 5, 1879.

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Hæmatocele of Neck.—J. C——, aged forty-five, a compositor, was admitted July 9th, 1878, into Charing-Cross Hospital, under the care of Mr. Barwell, with the following history: He had always been a fairly healthy man, and had been married for twenty-four years. Was the father of six children, five of whom were alive. About fifteen years ago he first noticed a swelling on the right side below the angle of the jaw; this was about the size of a pullet's egg, freely movable beneath the skin. About the middle of April, 1878, he had an attack of typhoid fever, which left him in a weak state. During convalescence the tumour increased very rapidly in size and became extremely tender to the touch and the seat of "burning pain." The only explanation he could offer of the origin of the tumour was that it arose from a blow he received whilst boxing.

On admission a large irregular swelling occupied the right side of the neck, about the size of the full-term fœtal head. It extended from the lobule of the right ear downwards to the sternal end of the clavicle, and lay in the course of, and underneath, the sterno-mastoid muscle, which was freely movable over it, but atrophied and expanded by pressure; it went as far back as the middle line of the posterior triangle, and along its inner border communicated pulsation could be readily distinguished. It was smooth, tense, and very hard. It was the seat of constant pain, and was very tender to touch.

On the 16th of July, by careful palpation, Mr. Barwell detected a spot near the middle of the posterior border in which he believed an indistinct fluctuation could be felt; he therefore introduced an exploring trocar and canula with some difficulty, owing to the density of the tissues. When this had passed to the depth of an inch and the trocar withdrawn, three ounces of a dark-brownish sanguinolent fluid, having the odour of sulphuretted hydrogen, was discharged.

On July 19th, at noon, the patient had a well-marked rigour; temperature 104°. There was no inflammatory signs in or about the tumour to account for this.

On July 25th, an oblique incision was made along the posterior border of sterno-mastoid muscle, and a dissection carefully made down to the tumour so as to avoid some rather large veins. The cyst was then opened by a small incision, into which the forefinger could just be introduced, and there flowed out by the side of the finger some dark grumous blood, having less fetor than that which escaped by trocar. Some clots were next broken down, and some dark decomposed blood was allowed to pass by the side of the finger. As no arterial hemorrhage followed, a long narrow-bladed bistoury was passed along the finger, and the opening enlarged to the extent of about an inch. Thirteen ounces of dark blood, fluid and clotted, came away, which, with the three ounces previously withdrawn, made up the whole quantity to sixteen ounces, but a quantity of coagulated blood was left, being strongly adherent to the walls of cavity, and very dense. The operation was conducted with all antiseptic precautions. The tumour was cystic in origin, its walls very thick and dense, and the interior rough and fasciculated. Its contents were nothing but disintegrated blood. The microscope showed a great quantity of granular matter, a number of round bodies about the size of blood-disks, and with the outlines of cells, as well as a considerable amount of finely fibrillated material.

Remarks.—Hæmatocele of the neck is not a common affection, and rarely attains the size of the blood-tumour in this case. One of the man's amusements—namely, sparring—might probably account for the disease, for when a young man he had himself observed that when a professional boxer allowed himself to be hit about the head he always turned his head and chest so as to receive the blow upon the side of the neck—in fact, upon the sterno-mastoid muscle, rendered tense. A sharp blow, or a succession of blows, received on this place might easily, by the rupture of a vein, have given rise to the tumour. But the chief interest lay, not in its causation, nor in its rarity, but in the great difficulty of diagnosis. The tumour lay in the course of great bloodvessels; it pulsated, and, as the sequel showed, contained blood, and yet was not an aneurism. The diagnosis before the use of exploration was most difficult, as the swelling might, but for certain small differences, have been a partially consolidated aneurism of the carotid, into which the introduction even of a very fine trocar would have been most dangerous. These differences were: the character of the pulsation; its almost entire limitation to the line of the carotid artery; the fact that the temporal and other arteries beat nearly as strongly as on the opposite side; the great tenseness and hardness of the tumour, and the power of shifting it, though very slightly, outwards, without moving simultaneously the vessels of the neck. Yet these differential signs, plainly diagnostic when thus catalogued, could, owing to the size of the tumour and the great condensation of the surrounding tissues, be made out only by most careful examination. Neither did the character of the blood evacuated by puncture entirely clear away the possibility of the tumour being aneurismal; hence the opening was made in a manner which might, if necessary, allow it to be converted into the old operation for aneurism.—*Lancet*, June 21, 1879.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

On Disinfection for limiting the Spread of Yellow Fever.—The National Board of Health publishes (*National Board of Health Bulletin*, Aug. 2, 1879) the following memoranda on disinfection:—

1. It is prudent to assume that the essential cause of yellow fever is what may for conciseness be called a "germ," that is, something which is capable of growth and propagation outside the living human body; that this germ flourishes especially in decaying organic matter or filth, and that disinfection must have reference both to the germ, and to that in or on which it flourishes.

2. Disinfection, when used in a place not infected, for the purpose of rendering filth, or foul soils, waters, etc., incapable of propagating disease germs, is a poor substitute for cleanliness, and is mainly useful to make the process of cleansing odourless and harmless. The best disinfectants for this purpose are sulphate of iron, carbolic acid, fresh quick-lime, fresh charcoal powder, chloride of zinc, chloride of aluminium, and permanganate of potash.

3. The two great difficulties in destroying the vitality of the germ of yellow fever are, first, to bring the disinfecting agent into actual contact with the germ; and, second, to avoid injuring or destroying other things which should be preserved.

4. *When the germ of yellow fever is dry or partially dried no gaseous disinfectant can be relied on to destroy it.* It must either be moistened or subjected to a dry heat of not less than 250° F. to obtain security.

5. In disinfecting or destroying infected clothing, bedding, or movable articles, *move them as little as possible while dry.* Before disturbing them have them thoroughly moistened either with a chemical disinfecting solution or with boiling water, in order to prevent the diffusion of dried germs in the air in the form of dust.

6. The best method of disinfecting rooms, buildings, ships, etc., is still doubtful, owing to the difficulty of destroying the vitality of dried germs.

The Board proposes to have this subject carefully investigated, and in the mean time advises thorough scrubbing and moist cleansing to be followed by the fumes of burning sulphur at the rate of 18 ounces per 1000 cubic feet of space to be disinfected.

The sulphur should be broken in small pieces, burned over vessels containing water or sand, which vessels should be distributed in the closed space to be disinfected at the rate of one to each of 100 square feet of area of floor.

7. No patented compound known to to the Board is superior as a disinfectant to the agents above mentioned, and none so cheap. Some of these patent disinfectants are good deodorants, but *the removal of an unpleasant odour is no proof that true disinfection has been accomplished.*

8. In districts where yellow fever prevailed last year the following precautionary measures should be taken:—

(*a*) Textile fabrics of every description which were exposed to yellow fever infection during the year 1878 and which have remained packed or boxed in a closed place since such exposure, should not be opened or unrolled, but should either be burned or placed in boiling water for half an hour or more, or in suitable heated ovens, or disinfected according to the nature and value of the individual article or articles.

(*b*) Every house or room in which cases of yellow fever occurred in the year 1878, and since that time have remained unoccupied, should not be opened for occupation until they have been thoroughly cleansed and disinfected by persons acclimated to yellow fever.

(*c*) Every privy, vault, underground water-cistern, dry well, or closed cellar connected with a house in which yellow fever existed last year, and which may not have been opened since that date, should not be reopened, but if possible should be covered with several feet of earth.

(*d*) Every suspicious case of sickness should be at once isolated, and every possible precaution taken to prevent infection by providing attendants who have had the disease, and thorough disinfection of all discharges from the sick. If the disease prove to be yellow fever all articles of clothing and bedding used about the sick should be burned, the house should be vacated, and every room tightly closed and fumigated with burning sulphur.

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Medical Officers as Inspectors of Foreign Ports.—In response to the request of the National Board of Health, the Secretary of the Navy has detailed Dr. Daniel M. Burgess for the inspection of vessels and issuing certificates at Havana, and Medical Inspector Somerset Robinson for like duty at Matanzas.

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Colour-Blindness among Railroad Employés.—It is stated in the *Nation* (Aug. 21, 1879) that Dr. B. JOY JEFFRIES has made an official examination of ninety-four engineers, firemen, and switchmen of the Boston and Lowell Railroad, with the result of proving two of these employés to be colour-blind (red-blind), and seventeen to be "below the visual standard," whether as regards acuteness of vision or perception of colour.

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American Ophthalmological Society.—The annual meeting of this Society was held at Newport on July 24th. Dr. H. D. Noyes, of New York, President, in the Chair. The following officers were elected for the ensuing year: President, H. D. Noyes, M.D., of New York; Vice-President, W. F. Norris, M.D., of New York; Secretary, Dr. R. H. Derby, of New York. The next annual meeting will be held at Newport, in July, 1880.

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American Otological Society.—The annual meeting of this Society was held at Newport, R. I, July 23, Dr. Albert H. Buck, of New York, presiding. The following officers were elected for the ensuing year: President, Albert H. Buck, M.D., of New York; Vice-President, Charles H. Burnett, M.D., of Philadelphia; Secretary, Dr. J. J. B. Vermyne, of New Bedford, Mass. The next meeting will be held at Newport, in July, 1880.

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Iowa State Medical Society held its twenty-seventh annual meeting at Davenport, June 3d, 4th, and 5th. Dr. A. M. Carpenter, of Keokuk, President, in the Chair. The following office-bearers were elected for the ensuing year: President, Dr. George P. Hanawalt, of Des Moines; Vice-Presidents, Drs. A. W. McClure, of Mt. Pleasant, and D. Schofield, of Washington; Secretary, Dr. J. F. Kennedy, of Des Moines. The next meeting will be held at Des Moines, on the second Tuesday of January, 1880.

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Medical Society of North Carolina held its twenty-sixth annual meeting at Greensborough, May 20th, Dr. Charles Duffy, Jr., of Newbern, presiding. The following officers were elected for the ensuing year: President, Dr. J. F. Shaffner, of Salem; Vice-Presidents, Drs. J. K. Hall, of Greensborough, W. C. McDuffie, of Fayetteville, W. R. Wilson, of Granville, and R. F. Lewis, of Luncketon; Secretary, Dr. L. J. Picot, of Littleton.

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Medical Association of Montana.—A Territorial Medical Society was organized, January 29, 1879, under the name of "The Medical Association of Montana," and the following officers were elected for the ensuing year: President, Dr. E. T.

Yaqu, of Virginia City; First Vice-President, Dr. Wm. Parberry, of White Sulphur Springs; Second Vice-President, Dr. G. W. Monroe, of Bozeman; Recording Secretary, Dr. W. R. Bullard, of Helena.

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Medical Department of Yale College.—The medical department of Yale College announces a graded course of instruction extending over three years. Preliminary examinations are required for admission, except from those who present a degree in Letters or Science, or have passed an examination for admission to Yale College or some similar institution, and are conducted in writing. Examinations chiefly in writing, will be held at the end of each year to determine the standing of students with reference to their advancement to the studies of the succeeding year.—*Med. Record*, August 23, 1879.

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The Gross Testimonial.—The committee having in charge the arrangements for the complimentary dinner tendered to Prof. S. D. Gross by his medical friends in April last, have just published in neat pamphlet form a report of the proceedings on the occasion. The volume, which contains all the addresses, is prefaced by an excellent photograph of Prof. Gross, and is published by Lindsay & Blakiston.

FOREIGN INTELLIGENCE.

New Method of Preventing Cystitis after Cantharides.—M. Guyot recommends (*Le Progrès Médical*, May 31, 1879), the incorporation of a certain quantity of carbonate or bicarbonate of soda in place of powdering blisters with camphor, as is generally done. For this purpose he mixes equal parts of carbonate of soda and cantharides powder, and then spreads the mixture upon the plaster. The blister is fixed by strong pressure with the palm of the hand, and is covered with a layer of oiled silk. The vesicant acts as rapidly and as surely as one made with the simple powder of cantharides without any admixture with other substances. The experience of the many years during which it has been in use at the Bordeaux hospitals tends to show that the addition of the soda salt is a much safer preservative than camphor against those accidents to the neck of the bladder which occur so frequently after the application of blisters, whether or not they have been previously camphorated. — *Practitioner*, August, 1879.

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Treatment of Scrofula and Tuberculosis.—Dr. Jules Regnard has prescribed the chlorhydro-phosphate of lime in a case of tuberculosis after scrofula in a child with the greatest success. The preparation was given to the extent of a tablespoonful at each meal without any other treatment except careful dietary, fresh air, sunlight, and exercise. Commenting upon this case, Dr. Regnard wishes it to be distinctly understood that he has no intention of throwing into disrepute other modes of treatment. That phthisis is not a simple disease is well known. There appears to be one dominant condition more especially marked at the commencement of the disease—a general poverty of the system, which, at first a result of the disease, at a later period favours its further development. It is in this state that the beneficial effect of the chlorhydro-phosphate of lime are most chiefly noticeable. This remedy restores and stimulates the appetite, which has been long lost, to a greater extent than any other. It facilitates digestion and assimilation, and it acts directly upon the general as well as upon the local conditions. Side by side with this dominant affection, however, various symptoms call for special treatment. Thus in the majority of cases creosote is used for the purpose of moderating expectoration, and because it appears to possess a kind of topical action. Sulphate of atropia gives good results in sweating. In certain cases, too, arsenic is beneficial, and every one has experienced the remedial effects of hygienic treatment, and a change of scene chosen judiciously for each case. Cod-liver oil, which is so generally employed, may also afford great benefit whether it be used alternately with the chlorhydro-phosphate of lime, or simultaneously with that remedy, by rendering its digestion more ready. No means should therefore be left untried, but, although varying symptoms should be treated with a variety of remedies, the chlorhydro-phosphate of lime should be employed in every case of simple phthisis. — *Practitioner*, August, 1879.

Anæsthesia produced by the Inhalation of Iodoform.—A gentleman, aged twenty-five, was attended for suspected ulceration of the urethra, and a gram of finely-powdered iodoform was prescribed that he might make a local application. On the following day, towards evening, as he had not been seen since the previous night, his friends determined to enter his room. They did so, and then found him extended upon his bed in a deep sleep. As he did not answer to repeated shouts he was well shaken, and was at length aroused. The patient was unable to account for his abnormal sleep, and it was known that he had not committed any excess on the previous day. Two hours after awakening, and after a copious repast, his clothes and breath still smelt strongly of iodoform, the box containing which had been found on his bed with the powder scattered about. No ill effects, with the exception of a slight giddiness, were experienced. The case is interesting from the fact that so small a quantity as a single gram of iodoform, and that only in small part absorbed by the mucous membrane of the respiratory tract, shall have provoked so complete anæsthesia for twenty-four hours. During the whole of this time, too, the air in the room was being constantly renewed, since one of the windows was partially open. Experiments made upon a variety of animals in regard to the inhalation of iodoform have hitherto shown that it only produces a transient anæsthesia, with symptoms which recall those produced by protoxide of nitrogen, and in no case a deep and persistent sleep. (*Le Practicien*, March 17, 1879.)

Two somewhat similar cases are reported in the *Lancet* for May 31st. The maximum dose was .8 gram daily in a pill, and the symptoms resulting were those of poisoning, and not of mere anæsthesia. The cases were two in number, and were published by Oberlander. The symptoms of poisoning occurred in one case (a woman of twenty-six years of age) after forty-two grams of iodoform had been taken in eighty days; in the other case (a woman sixty nine years of age) after five grams had been taken in the course of seven days. The symptoms produced were giddiness, vomiting, and deep sleep, from which the patient could be roused with difficulty. This somnolence was interrupted by periods of excitement, each lasting several hours, and was followed by delirium, intense headache, sense of impending death, spasmodic contractions of the facial muscles, and in the case of the younger patient, diplopia. The functions of the other sensory organs were not disturbed, and the pupils presented a normal reaction. Deep inspirations alternated with apnœa of about half a minute's duration. After five or six days the toxic symptoms gradually lessened and passed away.—*Practitioner*, August, 1879.

Sodium Benzoate in Infectious Diseases. —Prof. Klebs, of Prague, announces (*Der Practische Arzt.*, Jan. 1879), that the benzoate of soda is the best antiseptic in all infectious diseases. It may be taken in large doses with impunity, and acts so far as the author's experiments upon animals show, as a more powerful disinfecting agent than quinine or salicylate of soda. The experiments were conducted upon animals inoculated with diphtheria and tubercle, and the benzoate of soda was injected hypodermically. Prof. Klebs, reasoning from the results obtained with rabbits, argues that in a man weighing fifty kilograms a daily dose of 30–50 grams of benzoate of soda would render the poison of diphtheria inoperative. Such large quantities, however, do not appear to be absolutely necessary, as the infection can be successfully combated in men by the administration of much smaller amounts. Thus 25 grams per diem may be given with good results, though the more ordinary dose is 10–15 grams in the same time. The mean of these amounts is probably the best. The drug may be mixed with twice its weight of Elæo. sacch. menthæ, 6–15 grams of the powder being given for a dose dissolved in half a wineglassful of water. Sodium benzoate is prepared by dissolving crystallized benzoic acid in water, neutralizing at a slight heat with a solution of caustic soda, drying and then allowing the solution to crystallize over sulphuric acid under a bell-glass.—*Practitioner*, August, 1879.

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Sodium Salicylate in Chronic Rheumatism.—Mr. **Ernest H. Jacob**, late Resident Physician to the Leeds Infirmary, in a communication to the *British Medical Journal*, Aug. 2, 1879, says there are few better established facts in the history of therapeutics than the success in acute rheumatism of treatment by the salicylates. Very little evidence, however, has been given of its effect in the chronic forms. A few observers, after a short trial, declared it useless; and few voices have been heard in its defence.

In a paper read before the British Medical Association in 1877, I gave short notes of about thirty cases so treated. I have now accounts of 57 more, all well marked cases of chronic articular rheumatism treated during the two past years as out-patients at the Leeds Infirmary. Making the usual allowance for the imperfection of out-patient notes, I find that, out of the whole number of cases in which the drug was given, viz., 103, 16 did not return after the first visit. Next, out of the 87 of whom notes had been taken, 61 (70 per cent.) derived some benefit from the drug, which was in most cases sodium-salicylate in doses of fifteen to thirty grains three times a day. The remaining 26 felt no improvement, and in four cases some sickness was noted. In comparatively few of the cases was the relief given as speedy as that afforded in the acute disease; but, considering the generally unsatisfactory nature of the treatment of chronic rheumatism by drugs, I think we may say that sodium salicylate deserves a further trial.

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A New Preparation of Quinia soluble in Water.—In the *Centralblatt f. d. Med. Wiss.*, June 14, Dr. **Jaffe**, of the Hamburg General Hospital, reports the results of the trials which he has made of a new preparation of quinine termed *quinia bimuriatica carbamidata*, formed by Drygin, from a combination of twenty parts of muriate of quinia, twelve of muriatic acid, and three parts of urea. The resulting salt is soluble in equal parts of water, and is therefore eminently suitable for the administration of large doses of quinine by the hypodermic method. The trials that have been made of it at Hamburg have proved so successful that it is highly desirable it should be more widely known. A 50 per cent. solution has always been employed, so that a Pravaz syringe full (holding one gramme) will contain a third of a gramme of the salt. The quantity injected varied from a half to three syringes full. The local irritation consequent on the injection was in most cases very slight, and at most consisted in a circumscribed burning pain (which was soon relieved by cold Goulard water), without redness or swelling. Doses of a gramme produced in men scarcely any subjective sensations, and the noises in the ear complained of by women and children soon disappeared. The anti-febrile effects were evident and certain, intermittents disappearing after the second or third injection. This form of administration seems especially indicated (1) in those sensitive persons who have an invincible objection to taking quinine by the mouth; (2) when gastric affections coexist; (3) in children; and (4) in hospital and pauper practice, as a much smaller quantity of quinine is required than when it is administered internally. —*Med. Times and Gazette*, July 12, 1879.

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Death from Chloroform.—The *British Medical Journal* for July 19 contains a report of a case of this. An inquest was recently held at Mildenhall, in Suffolk, on the body of a girl aged 14 years, who had died at the St. Leonard's Cottage Hospital at that place, during an operation whilst under the influence of chloroform. The medical evidence showed that the girl was admitted for inflammation of the elbow-joint. Abscesses formed in the arm which required opening, and she had been twice chloroformed during the performance of operations. On the third occasion, when fresh abscesses had shown themselves, the chloroform was taken very easily and calmly, but the breathing soon became noisy and embarrassed, and the lips and face began to turn livid. The usual restoratives were applied without avail, and death ensued.

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Intra-uterine Therapeutics.—Dr. CNOPF of Nuremberg (*Memorabilien*, part 5, 1879) has lately tried the experiment of treating rachitis during intra-uterine life. The patient was a woman who had given birth to several rickety children. Both parents were seemingly healthy, but showed traces of rickets. Dr. Cnopf treated the woman with phosphates for several months previously to her delivery. A very well formed healthy male child was born, which did not present the slightest symptoms of rickets.—*British Med. Journal*, July 19, 1879.

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Uterine Temperatures.—Dr. RUNGE, in making experiments on rabbits, found that as soon as the temperature of the maternal organism rose to 105 8° Fahr., the fœtus perished, though it was alive at a temperature of 104.9° or 105.2°. Professor Zweifel observed a similar fact in a human fœtus. As long as the maternal temperature was 105.8°, the fœtus was alive; but when it rose to 108.6°, the child died.—*British Med. Journal*, June 14, 1879.

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The Cystoscope.—The following description of this instrument, which has been invented by Dr. Nitze, and constructed by M. Leiter, is taken from the *Allgemeine Wiener Medicinische Zeitung*, May 13th. The cystoscope, or instrument for illuminating the urethra and bladder, consists of a long tube or catheter, which ends in a point, and into which another tube with very thin walls, containing the optical apparatus, is inserted. A platinum wire, which is heated to white heat, runs through the outer tube, in the tapering end of which a small opening is cut and provided with a well-fitting glass. Two different instruments are required here, one only for the purpose of examining the urethra in all its parts, and the other for examining such portions of the wall of the bladder as would stand perpendicularly to the longitudinal axis of the instrument, whatever may be its position. Therefore, in the first cystoscope, the opening is situated on the convex part of the angle, which is formed by the point and the remainder of the tube, and necessarily on the anterior part of the former; and in the second cystoscope on the concave part of the same angle and on the posterior part of the point. Into the opening of the cystoscope No. 2 is fitted a rectangular prism. Its hypothenuse acts as a mirror in reflecting the rays of light which fall on it. This latter instrument is so contrived that it can be rotated around its longitudinal axis without interrupting either the electrical current or the water-supply. The wire is heated and maintained at the same temperature by means of a very powerful constant Bunsen's battery, which has been somewhat modified by M. Leiter. By a special contrivance, the air within the vessels which contain the acids may be either compressed or rarefied, so that the battery, which consists of two elements, can be filled or emptied in the space of five minutes. It can easily be moved, and may also be used for galvano-caustic operations. In order to prevent the heated wire from coming into contact with the mucous membrane, the tube itself is kept cool by means of a continuous stream of water which circulates within its walls through two separate channels, which run into each other at the point of the catheter. The space between these two channels is occupied by an isolated wire. The two poles are represented by the catheter and the above-named wire. A loop made of platinum wire and connected both with the tube and the isolated wire is placed at the confluence of the channels. In this way, the wire may be heated to white heat, while the tube remains perfectly cool. The water is supplied from a vessel which is suspended from a considerable height, and connected with an India-rubber tube. Two filters are placed within the latter, at a certain distance one from the other, for the purpose of keeping back any foreign bodies which might happen to be in the water and obstruct the instruments. A special automatic interrupter is provided for the purpose of breaking the contact the moment the water-supply should cease to flow. In short, the whole apparatus is most ingeniously contrived, and will doubtlessly prove a most efficient help to internal examinations. The instruments for examining the stomach, œsophagus, etc , are not yet completed.—*British Med. Journal*, May 31, 1879.

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The Audiometer —At the last meeting of the Royal Society, Dr. Richardson demonstrated the action of a new instrument which he has named the audimeter, or audiometer, and which has just been invented by Professor Hughes, the discoverer of the microphone. The audiometer is used as a precise measurer of the sense of hearing. It is formed of a small battery of one or two Leclanché cells, a new microphonic key, two fixed primary coils, a granulated insulated bar, to which at each end one of the fixed coils is attached, a secondary induction coil, which moves along the graduated bar, and a telephone, the terminals of which are connected with the terminals of the induction coil.

The principle of the audiometer is based on the physical fact that when the battery is in action, and a current is passing through the two primary coils, the secondary coil on the bar becomes charged, by induction, whenever it is brought near to either of the primary coils; but when it is brought to the precise centre between the primary coils there is a ne[illegible] point, or electrical balance, wh[illegible]tric phenomena from indu[illegible] to be manifested. By [illegible]ophonic key between the battery an[illegible] one of the primary coils, and by attaching the terminals of the induction coil to the telephone, Professor Hughes was able to make the telephone produce sounds whenever he brought the induction coil near to one of the primary coils and moved the microphonic key so as to make it play on a fine needle suspended in the circuit. When the induction coil is close to one of the primary coils, the noise is very loud, but as the coil is moved towards the centre of the bar the noise diminishes, until it ceases at the centre altogether. The scale on the bar is graduated into two hundred degrees, representing units of sounds from 200 to 0, or zero. At 200 all who can hear at all can hear the vibration of the drum in the telephone. At 0 no one can hear, while between the two points there are two hundred gradations of sound, from the highest down to zero.

In using the instrument, the telephone is put to the ear of the listener while the operator moves the microphonic key, and at the same time shifts the induction coil on the graduated bar so as to measure the hearing power of the person under examination. Dr. Richardson presented a preliminary report to the Royal Society on his first experiments with the audiometer, and showed that already, by its means, some useful and practical as well as curious facts had been obtained. Amongst many of these was one relating to an inquiry as to the best material for making artificial tympanums and the best form of artificial tympanums for cases of defective hearing from perforation or destruction of the natural drum. He had found gold made into the form of little cups or capsules exceedingly effective for this purpose. The audiometer promises to become one of those useful adjuncts to practice of which we shall say ultimately, How did we get on before it was known ?—*Lancet*, May 31, 1879.

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British Medical Association.—The forty-seventh annual meeting of this Association was held at Cork, on the 5th, 6th, 7th, and 8th of August, under the Presidency of Dr. O'Connor, of Cork. The following Americans were noted as among the distinguished foreigners who were present: Drs. Da Costa and Turnbull, of Philadelphia; Sayre, Loring, Agnew, Seguin, and John P. Gray, of New York; Yandell, of Louisville; Byford, of Chicago; Hogden, of St. Louis, and A. B. Palmer, of the University of Michigan. The meeting in 1880 will be held at Cambridge, and Professor Humphrey will be the President-elect.

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OBITUARY RECORD.—On July 4, aged 47, CHARLES FREDERICH MAUNDER, Surgeon to the London Hospital.

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We can heartily commend this volume to the medical student as a good guide to the study of laryngoscopy and rhinoscopy penned by the hand of a gentleman fully familiar with the subject of which he writes.—*N. Y. Med. Record*, July 19, 1879.

HENRY C. LEA—Philadelphia.

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VOL. XXXVII. OCTOBER, 1879. No. 442.

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CLINICAL LECTURES.

ON NASO-PHARYNGEAL CATARRH.

A Clinical Lecture delivered at the Jefferson Medical College Hospital.

BY J. SOLIS COHEN, M.D.,
Physician to the Hospital, Lecturer on Diseases of the Throat, etc., in the Jefferson Medical College, Philadelphia.

GENTLEMEN: We have before us a lad eleven years of age, and a young man twenty-four years of age, both of whom complain that they have suffered for a number of years with impediment to nasal respiration, and morbid discharges of various kinds from the nose and from the throat. The boy states that he has had his complaint for five years, nearly one-half of his existence therefore. Their symptoms as detailed to you in reply to the leading questions I put to them have been much the same, namely, that one side of the nose or the other is almost always stopped up, and that there is a more or less copious collection of thickened mucus, part of which is discharged by blowing the nose and part of which is hawked down at intervals from the back part of the nose and expelled through the mouth; that scabs or crusts are discharged at varying intervals of two or more days.

In addition to this, the boy volunteers the information that he suffers severely from headache just above his nose; and on questioning the other patient we find

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that he has never suffered in that way, And let me seize the opportunity right here to impress upon your minds the reason why there is headache in the one case and not in the other. You are aware from the description of the symptoms that the cases before you are examples of nasal catarrh. Now nasal catarrh is an inflammation of the nasal mucous membrane and of its contained glands, with hypersecretion from the diseased glands and from the epithelial layer of the membrane. The healthy nasal passages are in direct communication with certain recesses in the brow, *i. e.*, the sinuses of the frontal bones.

Now, as the mucous membrane lining the nasal passages is continuous with that lining all their communicating chambers, it is easy to understand that an inflammation may be propagated by continuity to any of these structures or to all of them. You are all doubtless familiar with the brow-ache and face-ache which often attend an acute cold in the head. These pains are due to the extension of the inflammation to the frontal and maxillary sinuses respectively; and in like manner our little patient's headache is doubtless due to similar extension, which does not exist in the other patient. Not only is there extension of inflammatory action to these sinuses in some instances of nasal catarrh, but the narrow channels of communication may become permanently clogged with the products of secretion, and the pent-up matters that accumulate may excite considerable disease in these regions. Abscesses, cystic tumours, and serious morbid growths in the frontal and maxillary sinuses sometimes originate in this way.

Let us recall the nature of the ground occupied by the disease. This comprises the nasal passages proper and the upper portion of the pharynx in proximity to them. When confined to the nasal passages, the affection is termed nasal catarrh, when occupying the pharynx also, it is naso-pharyngeal catarrh. Now we know that the nasal passages are not simple, smooth-sided tubes, but that they contain the scroll-like turbinated bones which render their outline tortuous. We know too, that they communicate behind with the upper portion of the pharynx, the roof of which bends forward to conform to the surface of the base of the skull. The mucous membrane covering all these parts is extremely vascular, and is supplied with great numbers of little secreting glands, in some portions much more copiously than others. There is one locality where there is a large accumulation of gland tissue, at the top of the pharynx just behind the upper portion of the back part of the septum of the nose, or in other words, just above the posterior nasal outlets. This mass of glandular tissue is exceedingly prone to become diseased in naso-pharyngeal catarrh, and the secretions from its surface either drop down upon the entrance into the windpipe and excite cough, or trickle down along the posterior wall of the pharynx, and form there yellowish masses so often seen coming down the back portion of the throats of individuals affected with the catarrh. The secretions sometimes dessicate in masses, which are eventually discharged as scabs or crusts.

The patients before you have complained of continuous copious accumulations of mucus which are difficult to get rid of; of occasional discharge of crusts, still more difficult to get rid of; and of foul breath.

The accumulations of mucus are due to excess of secretion from the glands, and admixture of cast-off epithelium: and the difficulty of getting rid of them is due in part to their tenacious clinging to the various sinuosities of the passages, and to another reason to which your attention will be specially directed in a few moments. The crusts are due to desiccation of the accumulated mucus; and their difficulty of discharge is due to the fact that they adhere to the surface until fresh watery secretion penetrates beneath them or actual suppuration lifts them from the surface. The foul breath is due to the evolution of fetid gases in the decomposition of these pent-up masses, which, being dead organic matters the moment they issue from the tissues, undergo decomposition just the same as they do when discharged into the spittoon.

One cause of the detention of mucus in the nasal passages is due to destruction of the epithelium; and the explanation about to be given applies equally to the entire respiratory tract. You know that mucous membranes are covered by layers of epithelium which are being continually shed and renewed, like the scales of epidermis which remain in the water after a bath. The outer layer of the epithelium of the entire respiratory tract proper, nasal passages, windpipe, and bronchial tubes, with the exception of the upper surface of the vocal cords, is a columnar epithelium, provided with cilia or hair like processes, continually waving in a direction from the interior to the exterior. The province of these appendages is to brush out, as it were, any dust, mucus, or what not, which may be in the respiratory tract, and thus to get rid of what may be injurious. In the nasal passages these cilia are continually brushing excess of mucus from the interior to the exterior. Now when the mucous membrane is diseased, numbers of these ciliated epithelia are destroyed and are not reproduced. Hence the accumulating mucus cannot all be brushed out. It clings to the irregular surfaces and undergoes decomposition. The gases of decomposition irritate the mucous membranes still further, and so does the mechanical retention of the masses themselves, and thus the disease is kept up and intensified; and a vicious circle is started which continues its round indefinitely, for, as in the cases before you, the disease is one that is liable to continue for a series of years.

What are we to do with these cases? The first thing is to examine the parts affected, and note their condition. We look into the nose of the patient, and find that it is more or less filled with thickened mucus. This must be gotten rid of before the parts can be properly inspected. It is necessary therefore to wash the parts out. This may be done by means of the syringe, the spray apparatus, or the nasal douche.

The process is the same precisely as is requisite daily, or more frequently, to rid the parts of the secretions as they accumulate, so as to make the first break into the vicious circle of cause and effect reacting on each other. Break up this circle by keeping the parts as thoroughly clean as possible, and your patient will be more than half cured. Cleansing, gentlemen, is the principal factor in the treatment, often efficient by itself to cure simple inflammatory cases. But it must be thorough. Relieve the diseased mucous membrane from the burden of these masses as they accumulate, and you give its blood a chance to regenerate fully formed ciliary epithelia which straightway begin to brush out the light layers of secretion themselves, and thus you gradually restore the normal condition. Even in cases of constitutional diathesis, this cleansing process is equally essential, though not so directly curative. Your constitutional remedies will be necessary to overcome the effects of the diathesis which interferes with the proper nutrition of the part; but the mechanical treatment is necessary to clear the way, and keep the way clear.

The fluid usually employed for cleansing purposes is tepid water at about blood heat, brought up to the specific gravity of the blood with some saline. We usually employ common table salt in the proportion of one drachm to the quart. In cases where the masses are very adherent, it is often better to use carbonate of sodium in the same proportion. Other ingredients used in similar manner are chloride of potassium and chloride of ammonium.

Stress has been laid on the necessity for as thorough removal of these masses of secretion, or excretion, as practicable. There is no other means of verifying thorough removal than frequent examination of the parts, anteriorly and posteriorly, by direct inspection and with the aid of a mirror passed behind the palate. It will frequently happen that an hour may be consumed in getting entirely rid of these accumulations; and it is my own custom to persevere until they are removed, unless the patient shows signs of great fatigue, or the parts give indication of undue irritation.

Sometimes the forceps, hair-pencil, or a wad of absorbent cotton can be used to detach matters within reach and which resist expulsion by the douche or syringe.

The simplest method of cleansing, which is very efficient when the masses of secretion are not excessive or very adherent, is to let the patient dip his nose into a vessel of warm salt water, and sniff it up by insufflation into the pharynx, discharging it by the mouth. A similar plan, though less efficacious, is to draw the fluid up from the palm of the hand, repeating it with the head in different positions so as to favour contact with the various surfaces in succession.

A syringe may be used, first on one side then on the other, the fluids escaping partly by the nose and partly by the mouth. The rubber-ball syringe is the most effectual. It is often advantageous to use a syringe with a long-curved nozzle to be passed behind the palate and then discharged through the nasal passages from behind forwards. To do this with least trouble you seat yourself in front of your patient, who is so placed that his mouth is well illuminated. Telling him to open his mouth, the instrument is passed flatwise over the tongue until the end of the nozzle is behind the palate. The instrument is then turned one-fourth way round so that the end of the nozzle is behind one posterior nasal outlet. You then place the disengaged hand on the top of the patient's head, and let him bend his head forward over a basin he holds in his lap, and then keeping the head down with the one hand, you discharge the syringe with the other. A few moments afterward, you repeat the process with the other nasal passage. It may be necessary to wash the parts out several times, continuing as long as any of the secretions are discharged. There is an advantage gained in letting the patient hold the basin. It keeps his hands occupied and he will not be likely to let the basin fall, so as to seize your own hand as he would be inclined to do if his hands were unemployed.

Another method of cleansing the nasal passages, which will be demonstrated on the young man before you, is to use what is known as Thudichum's nasal douche.

The apparatus consists of a bottle with a tubular offset at the bottom to which a rubber tube is attached carrying a glass nozzle at the other extremity. This nozzle is egg-shaped so as to occlude the nostril in which it is to be inserted. The vessel being filled with the cleansing solution, the nozzle is firmly inserted into one nostril, and the patient told to open his mouth and breathe through it exclusively, and to hold his head forwards over a bucket. As the bottle is raised the fluid descends by gravity and passes out by the free nasal passage.

The reason the liquid flows out of the free nostril and not out of the mouth is due to the fact that the nasal portion of the pharynx is shut off from the oral portion, during oral breathing, by the contraction of the palate against the pharynx. Hence the fluid runs through the one passage around the septum of the nose behind, along the posterior surface of the palate, and escapes by the other passage. The patient is to be cautioned against swallowing during the manipulation, lest the fluid be forced up the Eustachian tubes into the middle ear; where it might excite otitis media, as sometimes happens, not only in the use of the douche, but in every other method of cleansing the nasal passages, even the simplest of all, snuffing the fluid up from the palm of the hand. If movements of swallowing are avoided there will be but little likelihood of flooding the Eustachian tube, and if the fluid be warm there will be little danger of exciting inflammation of the middle ear even if the Eustachian tube be flooded; for, as you know, fluids are sometimes intentionally injected up the Eustachian tube in treating catarrhal affections of the middle ear. The first cleansing should always be performed under your own supervision to be certain that it is done correctly. After that it can be left to the patient himself, or to an intelligent attendant. About a quart of the fluid should be injected daily, or twice a day, one-half through each nasal passage.

Here are two other patients, man and wife, with naso-pharyngeal catarrh of two years' standing, for which they have been under treatment here for some three weeks. The man tells you that he uses douches of two quarts, every night, with great relief and copious discharge of secretions. He tells you also that his nose, which was very much swollen, is not now more than half the size it was when he began, and that he now has complete relief from severe frontal pain which had long attended his catarrh. The little boy, introduced to you at first, has had no other treatment than cleansing by the douche, and he is so much improved that we shall trust to that process for a while longer in the hope that it will result in complete cure, as it often does in subjects otherwise healthy.

Having cleansed the nasal passages we examine their interior by placing the parts before a good light and drawing the wing of the nostril aside by a hook improvised from a wire hair-pin by bending it in the form of an italic *S.* This is the simplest nasal dilator you can use, and for mere purposes of inspection, as efficient as anything more elaborate.

These patients have no ulcerations of the mucous membrane, and in simple inflammatory catarrhs ulcerations of the mucous membranes are exceptional. In tuberculous, scrofulous, and syphilitic subjects, however, ulceration is quite frequent. This ulceration may extend deeply and destroy the submucous tissues, the cartilages, and even the bones.

It frequently happens, as in the case of the female before you, that applications have to be made to the posterior portions of the nasal passages. An application will be made before you by an assistant in the clinic. You notice that he takes a rectangular probe on the end of which a small piece of sponge is securely fastened. He saturates this with a solution composed of equal parts of glycerite of tannin and compound solution of iodine, and, seating himself before the patient whose open mouth is well illuminated, he depresses the tongue with a spatula and passes the instrument behind the palate, when he depresses its handle and forces the sponge into the posterior nasal outlet of one side. In a few moments he repeats the process upon the other passage. This patient tells you that this little operation, which is repeated three times a week, always gives her considerable relief, which lasts a couple of days. We will continue the treatment.

We make use of the man to show you another method of local treatment by which a medicated solution is retained in contact with the parts for from twenty to thirty minutes. This is done by means of short flexible bougies composed of gelatine impregnated with the medicament, which, in this instance, is two grains of sulphate of zinc and a half grain of carbolic acid. A string runs through the bougie and extends some distance beyond it. This is for the purpose of securing the bougie so that it shall not drop into the throat. The bougie being inserted, the projecting portion of the string is fastened around the ear. In from twenty to thirty minutes the bougie will have become melted by the natural heat of the parts, and dissolved in their secretions, and the medicament will have become diffused over the mucous membrane.

Various other methods of treatment are employed in other classes of cases, which may be exhibited to you upon some subsequent occasion. What it is desired to impress upon you at present is the great value of thorough cleansing, itself often the principal element of curative treatment.

Getting rid of these accumulations you not only relieve the mucous membrane from the mechanical irritation they keep up, but you rid the air that is breathed of constant impregnation with the products of their decomposition, which impairs the general health, even in some cases to a condition of slow septic poisoning. Once the patient breathes uncontaminated air, his blood is invigorated, his appetite improves, his food is better assimilated; and thus his entire system reacts from depressing influences, and the diseased tissues take on a local healthy action which eventuates in recovery.

If other causes are at work keeping the disease up, as dead bone, foreign bodies, and the like, there will be no chance of curing the case until these sources of irritation are removed by proper procedures.

Congenital Affections of the Heart.—Dr. Arthur Ernest Sansom, in a recent clinical lecture on congenital affections of the heart (*Med. Times and Gaz.*, Sept. 6, 1879), concluded by presenting the following propositions:—

(1) In cases of congenital cyanosis in which no cardiac murmur is manifest, there is probably patency of the foramen ovale.

(2) In cases of cyanosis with systolic or pre-systolic murmur, varying in intensity, heard over the sternal ends of the third and fourth costal cartilages or the third intercostal space, there is probably patency of the foramen ovale.

(3) In cases of cyanosis with loud unvarying systolic murmur of maximum intensity internal to the position of the apex-beat, but heard also at the back between the scapulæ, there is probably imperfection of the interventricular septum.

(4) In cases of cyanosis *or of marked anœmia* in children who manifest a pronounced superficial systolic murmur at the base of the heart, there is probably constriction of the pulmonary artery or its orifice. Such murmur may be complicated by hæmic murmurs.

(5) In cases of congenital affection of the heart in which there is evidence of considerable dilatation of the left chambers, it is probable that endocarditis affecting the valves has constitued a complication.

As to the treatment of the unfortunate subjects of cardiac malformation, whilst giving due weight to the facts that a large proportion of the cases die within the first year of life, and that only about 15 per cent. attain the age of twenty, I am strongly of opinion that much good may be done by judicious management. This is, I think, evident from the consideration that some individuals—the subjects even of a congenital lesion of such evil significance as pulmonary stenosis—have attained the ages of forty, fifty, and even fifty-seven years, as recorded by Kussmaul, Peacock, and Stölker. It is most improbable that such patients should not go through periods of peril in which treatment is of much avail. The chief indications for treatment are to improve the conditions of cardiac force, to favour the oxygenation of the blood, to obviate the consequences of the deficient peripheral circulation, and to protect from adverse influences from without. I am sure that I have seen many cases greatly improve under treatment. The clothing of the little patients should be more than usually warm; the extremities—the temperature of which is sometimes so low as to be more than 20° under the normal—may with advantage be encased in cotton-wool. As regards internal remedies, I have seen the best results from the administration of iron and tincture of digitalis, the latter in small doses (♏ss to ♏iij), continued for periods of two or three weeks, with intervals of like length. Cod-liver oil is also often of essential service, and I think I have seen good result from its inunction in some cases. Thus, I think, we best fulfil the indications of improving the oxidation of the blood and increasing the *vis à tergo* of the right ventricle, whereby the pulmonic obstruction may be in a considerable degree overcome. The drawback to digitalis in these cases is that it sometimes induces sickness; and it is chiefly for this reason that I counsel its administration in very small doses. Some children are hopelessly intolerant of it. I do not think that there is any scientific reliance to be placed on the plan of treatment by chlorate of potash or peroxide of hydrogen, as has been recommended. It is, I consider, clear that chlorate of potash does not yield oxygen to the blood, but is eliminated unchanged; and as regards peroxide of hydrogen, it gives up its extra equivalent of oxygen so readily that long before it can be absorbed from the stomach it is no longer peroxide of hydrogen, but water.

HOSPITAL NOTES AND GLEANINGS.

Death from Extra-uterine Pregnancy Simulating Acute Irritant Poisoning.—The following case, reported by Mr. Frederick A. Gray (*Lancet*, Sept. 6, 1879), seems to be worth recording on account of its having given rise to a suspicion of poisoning. The chief points in the case appear to be—Firstly, the suddenness of the onset of symptoms soon after a meal;

secondly, their rapidly fatal character; thirdly, the severe vomiting; and, fourthly, the severe purging, which has rarely, if ever, been described as occurring in similar cases. These symptoms, occurring in an apparently healthy young woman, were so suspicious that the coroner considered an inquest necessary, and makes the case one of some toxicological interest.

S. H.——, aged twenty-six years, was a married woman, and has had four children; was last confined one year and nine months ago; has been suckling the child ever since. Her husband believes she has seen her courses for several months past irregularly. On January 4th, 5th, and 6th there was a bloody discharge from the uterus, and she thought her courses had come on. On the afternoon of the 6th she said she felt something in her stomach, but she seemed to be in her usual health, and said nothing more about it. On the 7th she took some broth at about 8 P. M.; at 9 P. M. she said she felt a pain in her stomach This was quickly followed by vomiting and purging, which increased in severity. She died at about 11 P. M. in a state of collapse. I was sent for, but found life extinct on arriving. As I could not give a certificate of the cause of death, an inquest was decided on by the coroner, after some delay.

A post-mortem examination was made on the 12th, the weather in the interval being dry and frosty. The body was found well nourished. Rigor mortis was well marked. There were no marks of any kind about the body, mucous membrane of mouth, etc. On opening the abdomen a large clot of blood became visible at the lower part, covering the great omentum. There was no evidence of inflammation. The bowels were collected in coils close to the spine, and were perfectly empty, except that they contained some round worms. The lower part of the abdominal and the pelvic cavities were filled with blood, measuring about two quarts. On examining the pelvis carefully, the uterus was found to be slightly enlarged; the ovaries were normal in size and position. On the right side, however, apparently in the broad ligament, was found a mass about the size of a walnut. The pelvic contents were removed altogether, and examined. The tumour mentioned above was found to be connected with the Fallopian tube, about an inch and a quarter from its fimbriated extremity. A bristle passed readily down the tube, till it was arrested by the mass. The mass consisted of blood-clot, over which the Fallopian tube was so stretched in parts that its structure could hardly be recognized. Unluckily the parts were preserved in spirit for some days, so that when the tumour was examined the fœtus could not be made out among the clots of blood, though in parts villi were plainly recognizable. The veins in the immediate neighbourhood of the tumour and in the broad ligament were much enlarged. At about the middle of the mass, at the back, was a hole of the size of a pea, with ragged edges, through which the blood found in the abdomen had evidently been poured forth. On opening the enlarged uterus the lining membrane was found thickened, and there was a small quantity of blood-stained mucus. The openings of the two Fallopian tubes were visible, and a bristle passed readily through the left, but was arrested on the right by the mass. The ovaries were normal, and the right had a well-marked corpus luteum. The large vessels in the abdomen were quite natural. All the other organs were healthy. The brain was not examined.

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Reduction of Old Dislocation of the Astragalus.—Mr. Fitzgerald relates (*Australian Med. Gaz.*, April) the case of a man, aged twenty-nine, who, five months prior to his admission to the hospital, had twisted his foot and dislocated the astragalus. The patient having been brought under the influence of chloroform, the tendo Achillis was first divided, and the tendon of the tibialis anticus being found in a tense state, and helping to wedge in the head of the astragalus, it was also divided. A long tenotome was then slid obliquely from about an inch in front and below the internal malleolus into the ankle-joint: and all the attachments between the tibia and the astragalus were freely divided, including some unbroken fibres of the anterior annular ligament. The knife was now carefully withdrawn, re-instated just over the front of the internal cuneiform bone, pushed obliquely backwards, and made to divide freely all the attachments between the scaphoid and bulging head of the astragalus; the blade being then carefully withdrawn, so as not to allow the entrance of air into the large cavity thus formed. Extension was now made with the foot, in the extremely extended position, and firm pressure backwards made on the astragalus. Suddenly the foot forcibly flexed on the leg, and the astragalus slipped into its normal position. The limb was bandaged to the knee, and the foot placed at right angles with the leg. The patient went on very well so that in three months the movements of his ankle-joint were pretty free, and he could walk moderately well. Mr. Fitzgerald stated that no case was on record in which reduction had been effected after the third month.—*Med. Times and Gaz.*, July 12, 1879.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Spinal Caries and Lateral Curvature by a New Paper Brace.—At a recent meeting of the Medical Society of the County of New York, Dr. A. MORGAN VANCE exhibited a method of applying a paper brace which was a departure from that of the plaster-of-Paris jacket. The principle consisted in the reproduction of any number of paper braces from the original plaster jacket, without having recourse to suspension of the patient. The following are the details of the procedure: A plaster-of-Paris jacket was obtained in the usual way and removed from the patient when sufficiently dry. It was then placed on the table and filled with plaster, and thus there was obtained a rough cast of the patient's body, which, after being smoothed off, served as the model of the paper braces. The plaster cast was first oiled and tightly rolled with an ordinary bandage; over this canton flannel was stretched, and secured at the back with a few stitches. A preparation of glue, which will be referred to again, was then applied to the canton flannel, and strips of manilla paper, one and a half inch wide, pasted on in a horizontal direction, each strip being sufficiently long to go half around the cast and overlap its fellow below. The posterior half of the cast was similarly treated. The ends of the strips overlaid each other sufficiently to give the requisite strength. Strips of hoop-skirt wire were then applied vertically, and secured in position by thread wound around. Another layer of paper strips was then pasted on vertically. The brace was completed by applying a coating of glue, and finally a roller bandage. In a few minutes the brace dried and was removed by cutting down anteriorly with a sharp knife and springing it off the cast. Perforations were made in it with a knife. After being lined with canton flannel and bound with leather, it was ready for use. The brace for lateral curvature differed only in the fact that sheet rubber was so applied internally that it made elastic pressure on the curvature. In order to do this it was necessary to build out the cast so that the paper brace would present a hollow on the side opposite to the curvature. The rubber thus was enabled to bring pressure on the curvature without any resistance other than the body.

Dr. Vance has a number of cases under treatment at the Hospital for the Ruptured and Crippled.

The formula for the glue used in the brace was white glue, 1 part; oxide of zinc, 2 parts; water, 6 parts. Dissolve the glue in the water, and add the zinc, stirring well to prevent precipitation.

Dr. L. A. SAYRE thought the brace of Dr. Vance had the merit of lightness, and would be of advantage in cases of lateral curvature. In Pott's disease of the vertebræ, however, he was of the opinion that any appliance that could be removed would fail to give as good result as the plaster jacket.

There were exhibited to the Society paper braces, similar in construction, for the knee and ankle, which combined strength and lightness, and seemed to present advantages over the felt splints used for similar purposes.—*New York Med. Journ.*, Aug. 1879.

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Instructions for Disinfection.—The National Board of Health publishes (*Nat. Board of Health Bulletin*, Aug. 30, 1869) the following circular on disinfection, prepared, under appointment of the Board, by Drs. C. F. Chandler, George F. Barker, Henry Draper, E. G. Janeway, Ira Remsem, and S. O Vanderpoel.

Disinfection is the destruction of the poisons of infectious and contagious diseases.

Deodorizers, or substances which destroy smells, are not necessarily disinfectants, and disinfectants do not necessarily have an odor.

Disinfection cannot compensate for want of cleanliness or of ventilation.

I. *Disinfectants to be Employed.*—1. Roll sulphur (brimstone) for fumigation.

2. Sulphate of iron (copperas) dissolved in water in the proportion of one and a half pounds to the gallon; for soil, sewers, etc.

3. Sulphate of zinc and common salt, dissolved together in water in the propor tions of four ounces sulphate and two ounces salt to the gallon; for clothing, bed-linen, etc.

Note.—Carbolic acid is not included in the above list for the following reasons: It is very difficult to determine the quality of the commercial article, and the purchaser can never be certain of securing it of proper strength; it is expensive, when of good quality, and experience has shown that it must be employed in comparatively large quantities to be of any use; it is liable by its strong odor to give a false sense of security.

II. *How to use Disinfectants.*—1. *In the sick-room.* — The most available agents are fresh air and cleanliness. The clothing, towels, bed-linen, etc., should at once, on removal from the patient, be placed in a pail or tub of the zinc solution, boiling hot if possible, before removal from the room.

All discharges should either be received in vessels containing copperas solution, or, when this is impracticable, should be immediately covered with copperas solution. All vessels used about the patient should be cleansed with the same solution.

Unnecessary furniture—especially that which is stuffed—carpets and hangings, when possible, should be removed from the room at the outset; otherwise, they should remain for subsequent fumigation and treatment.

2. *Fumigation* with sulphur is the only practicable method for disinfecting the house. For this purpose the rooms to be disinfected must be vacated. Heavy clothing, blankets, bedding, and other articles which cannot be treated with zinc solution, should be opened and exposed during fumigation, as directed below. Close the rooms as tightly as possible, place the sulphur in iron pans supported upon bricks, set it on fire by hot coals or with the aid of a spoonful of alcohol, and allow the room to remain closed for twenty-four hours. For a room about ten feet square at least two pounds of sulphur should be used; for larger rooms, proportionally increased quantities.

3. *Premises.*—Cellars, yards, stables, gutters, privies, cesspools, water-closets, drains, sewers, etc., should be frequently and liberally treated with copperas solution. The copperas solution is easily prepared by hanging a basket containing about sixty pounds of copperas in a barrel of water.

4. *Body and bed clothing, etc.*—It is *best* to burn all articles which have been in contact with persons sick with contagious or infectious diseases. Articles too valuable to be destroyed should be treated as follows:—

a. Cotton, linen, flannels, blankets, etc., should be treated with the boiling-hot zinc solution, introducing piece by piece, securing thorough wetting, and boiling for at least half an hour.

b. Heavy woollen clothing, silks, furs, stuffed bed-covers, beds, and other articles which cannot be treated with the zinc solution, should be hung in the room during fumigation, pockets being turned inside out and the whole garment thoroughly exposed. Afterward they should be hung in the open air, beaten, and shaken. Pillows, beds, stuffed mattresses, upholstered furniture, etc., should be cut open, the contents spread out and thoroughly fumigated. Carpets are best fumigated on the floor, but should afterwards be removed to the open air and thoroughly beaten.

5. *The corpse* should be thoroughly washed with a zinc solution of double strength, then wrapped in a sheet wet with the zinc solution, and buried at once. Metallic, metal-lined, or air-tight coffins should be used when possible, certainly when the body is to be transported for any considerable distance.

American Dermatological Association held its third annual meeting in New York, August 26, 27, and 28. A number of interesting papers were read, and the President, Dr. Louis A. Duhring, of Philadelphia, delivered an historical address on the "Progress of Dermatology in the United States."

The following officers were elected for the ensuing year: President, Dr. Duhring, of Philadelphia; Vice-Presidents, Drs. E. Wigglesworth, of Boston, and W. A. Hardaway, of St. Louis; Secretary, Dr. Van Harlingen, of Philadelphia. The next meeting will be held at Newport, on the last Tuesday in August.

American Gynecological Society.—The fourth annual meeting of this Society was held in Baltimore, September 17, 18, and 19, Dr. T. Gaillard Thomas, M.D., of New York, President, in the chair. The following officers were elected for the ensuing year: President, Dr. J. Marion Sims, of New York; Vice-Presidents, Dr. W. T. Howard, of Baltimore, and Dr. Robert Battey, of Georgia; Council, Dr. W. Goodell, of Philadelphia; Dr. E. W. Jenks, of Chicago; Dr. A. D. Sinclair, of Boston; Dr. A. J. C. Skene, of Brooklyn; Dr. J. R. Chadwick, of Boston, Secretary. Dr. P. F. Mundé, of New York, Treasurer. Dr. John Scott, of San Francisco; Dr. Edward L. Duer, of Philadelphia; Dr. R. Stansbury Sutton, of Pittsburgh, and Dr. J. W. Underhill, of Cincinnati, were admitted to membership.

The next meeting of the Society will be held at Cincinnati in September, 1880.

Bellevue Hospital Medical College. Changes in the Requirements for Graduation, etc. The Faculty of Bellevue Hospital Medical College, at a meeting held September 8th, adopted the following resolutions:—

That, after the regular session of 1879–80, the plan of instruction at the Bellevue Hospital Medical College be so modified as to apportion to each one of their sessions certain divisions of the study of medicine, with final examinations in elementary branches at the end of the first and of the second session; the examinations for graduation at the end of the third session being confined to the branches of practice of medicine, surgery, and obstetrics: the plan to embrace requirements as regards practical instruction in chemistry, histology, operative surgery, and clinical medicine, together with systematic recitations in all the branches.

In adopting this plan, the number of hospital lectures is not to be diminished, and the union of clinical with didactic teaching is to continue, as heretofore, to be a leading principle in the practical departments.

Resolved, That matriculants who expect to become candidates for graduation after the close of the session of 1879–80 will be required to furnish, by examination or otherwise, satisfactory evidence of a preliminary education deemed sufficient for entering upon the study of medicine.

The *matriculation examination* will consist of English composition (one foolscap page of original composition upon any subject, in the handwriting of the candidate); grammar, an examination upon the above-mentioned composition; arithmetic, including vulgar and decimal fractions; algebra, including simple equations; geometry, first two books of Euclid.

The matriculation examination by the Faculty will be waived for those who have received the degree of A. B., those who have passed the freshman examination for entrance into any incorporated literary college, those who present certificates of proficiency in the subjects of the matriculation examination from the principal or teachers of any reputable high-school, those who have passed a matriculation examination at any recognized medical college, or at any scientific school or academy in which an examination is required for admission, and those who present certificates of having passed the matriculation examination from certain examiners appointed by the Faculty of the Bellevue Hospital Medical College.

The following schedule of examinations for students who take the full course of three years has been adopted:—

First year—Physics and Inorganic Chemistry; Descriptive Anatomy: Materia Medica. *Second year*—Organic and Physiological Chemistry; General and Surgical Anatomy; Physiology; Therapeutics. *Third year*—Practice of Medicine; Surgery; Obstetrics and Diseases of Women and Children. Before the final examinations for the third year, candidates must present certificates from recognized teachers of one course of instruction in each of the following-named practical studies: viz., Dissections, Practical Chemistry, and a Practical Course of Physiological and Pathological Histology. No graduating thesis is required.

The regular winter session will be extended to six months, beginning about the middle of September and ending about the middle of March. Three courses of lectures will be required for graduation. The fees for the first two years will be $140 each, and for the third or last year $100, with an annual matriculation fee of $5, and an annual examination fee of $10.

The above regulations will apply to those students only who begin their attendance with the session of 1880–81.

We note with pleasure these changes, and are glad to find Bellevue boldly throwing the weight of its influence and example in favour of a more thorough education for the medical student of the future. Whilst these new regulations may result in a diminution of size in the classes, and, therefore, in a diminution of income, we feel sure that the loss will be only temporary, and that the mass of the profession will take pleasure in giving its support to those schools which, like Bellevue, the University of Pennsylvania, and Harvard, have initiated these changes, at the risk of a pecuniary sacrifice, that a better medical education may be afforded their students.

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Miners' Hospital, Pennsylvania.—At a stated meeting of the Schuylkill County (Pennsylvania) Medical Society the following preamble and resolution were offered by Dr. D. W. Bland:—

Whereas, The prospect for the erection of a General Miners' Hospital in the anthracite region is now about to be fulfilled, the Schuylkill County Medical Society feeling a common interest in the success of said hospital, therefore—

Resolved, That Dr. G. W. Brown, Dr. D. J. McKibben, and Dr. J. T. Carpenter are hereby appointed as a representative committee from the Schuylkill County Medical Society, whose services are offered to the commission of said hospital to aid and assist in the perfection of such plans in building as will combine all the modern improvements in the construction of general hospitals.

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Surgeon-General U. S. Navy.—Dr. Philip S. Wales, Medical Inspector U. S. N., has been appointed Chief of the Bureau of Medicine and Surgery of the Navy, with the relative rank of Commodore, to succeed Dr. J. Winthrop Taylor, retired. Dr. Wales is a native of Baltimore, a graduate of the University of Maryland, and is the author of a work on *Surgical Operations and Appliances*, published in 1867.

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Ex-Surgeon General Hammond.—The Secretary of War, under direction of the President, and by authority of Congress, has reviewed the proceedings and findings of the Court Martial of January 16, 1864, by which Surgeon-General Hammond was dismissed the service, and recommends that the findings and sentences be annulled and set aside in accordance with the authority conferred by the Act of March 15, 1878, and that the name of William A. Hammond be placed on the retired list of the army as Surgeon-General, without, however, back, present, or future pay allowance, as Dr. Hammond distinctly disclaimed any desire for such. The recommendation of the Secretary of War has been approved by the President, and Dr. Hammond's name has been placed on the retired list of the army as Surgeon-General, to date from August 27, 1879.

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Obituary Record.—Died at Richmond, Mass., on the 20th of August, aged 79, **Jerome Van Crowninshield Smith**, M.D., formerly editor of the *Boston Medical and Surgical Journal.*

—— At Philadelphia, on the 8th of September, aged eighty-two, **Clement A. Finley**, M.D., Ex-Surgeon-General U. S. Army.

Dr. Finley was a native of Pennsylvania; he entered the Army in 1818 as Surgeons' Mate, and subsequently became Assistant Surgeon, and served as Medical Director during the Black Hawk, Seminole, and Mexican Wars. In 1861 he succeeded Dr. Lawson as Surgeon-General of the Army, and in the following year he was retired on his own application after an active service of forty-four years.

FOREIGN INTELLIGENCE.

The Arrest of Vomiting in Pregnancy.—Dr. L. **Rosenthal** publishes, in the *Berliner Klinische Wochenschrift* of June 30th, a paper on the treatment of vomiting during pregnancy by Dr. Copeman's method. He distinguishes three forms of the affection: 1. Vomiting in the morning during fasting; this generally sets in early in the period of conception, and may cease when the movements of the fœtus are first perceived; 2. Vomiting at various periods of the day, especially after meals; 3. Obstinate vomiting, resisting all medicinal treatment and dietetic regimen. After a review of this subject, with reference to several British and Continental authorities thereon, Dr. Rosenthal says that the perusal of Dr. Copeman's communications in the *Brit. Med. Journal* led him to try the method of dilatation of the os uteri in two cases which have occurred in his practice. The first case was that of a woman aged 34, who had been much troubled with vomiting during her first pregnancy. In her second pregnancy, which followed a few months after the first, she was again attacked with vomiting after nearly every meal. Although not remarkably prostrated, she was much troubled with the frequent vomiting, and sought Dr. Rosenthal's aid. He found the os uteri capable of admitting the tip of the finger. By means of rotatory movements, he introduced his finger as far as the middle of the last phalanx into the cervical canal. After this, there was no more vomiting; and when he wrote, the woman was expecting to be soon confined, and was altogether in a very satisfactory condition. The second patient was a primipara aged 30, suffering from obstinate vomiting; she had been pregnant two months. In this case, a second introduction of the finger into the cervical canal was necessary; this arrested the vomiting, which did not return. Dr. Rosenthal says, that, in our present ignorance of the causes of obstinate vomiting during pregnancy, he cannot explain the *modus operandi* of Dr. Copeman's method; but he hopes that it will become more generally known.—*British Med. Journ.*, Aug. 2, 1879.

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Accidents from Partaking of the Flesh of Diseased Animals. — The *Revue des Sciences Médicales* for July 15, 1879, publishes an account of a series of accidents, caused by eating some ox-beef from an animal which had been ill with malignant pustule. Two hundred and thirty-three individuals were taken ill with violent headache, vomiting, diarrhœa, colic, and syncope. Eight of the patients have since died. Ninety-four persons partook of raw meat; of these, thirty-eight became seriously ill; twenty-nine presented milder dangerous symptoms; and four died. Of fifty individuals who ate the meat stewed, one was dangerously ill, four were less seriously so, and forty-five presented only slight symptoms of poisoning. Thirty persons were taken ill after eating sausages which had been prepared with the blood and liver of the diseased animal; four of these were very seriously ill, three seriously, and twenty-three only slightly indisposed; two died. Twenty-seven individuals ate the meat roasted; eight of these were very ill, and nineteen only indisposed. Three persons were poisoned by partaking of smoked sausage; two of these were dangerously ill. The same meat salted and then boiled only produced slight symptoms of indisposition in two individuals.—*British Med. Journ.*, Aug 30, 1879.

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Sudden Death during the Extraction of a Tooth.—Dr. A. Poulet, in his treatise on *Foreign Bodies in Surgery*, mentions several cases where a tooth slipped into the larynx while it was being extracted, and gave rise to very dangerous symptoms. Two of these cases proved fatal. It is noteworthy that in these latter cases the patients had been rendered insensible by nitrous oxide. A few weeks ago, a similar deplorable accident took place at a dentist's in Paris. The patient was a child, aged 7, who was having a molar tooth extracted. The child struggled violently, and the tooth slipped from the forceps into the larynx. The patient died on the spot, of suffocation. This case is not unlike one described by M. Rigaud, who saw a child upon whom he was operating for hare-lip die under his hands. The necropsy revealed a milk-tooth sticking in the rima glottidis, and completely obstructing the opening.—*British Medical Journ.*, Aug. 30, 1879.

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Magnesium Intestinal Calculi.— Dr. Blondeau relates (*Journ. de Therap.*, July 24) the case of a patient who, having been in the habit of taking four teaspoonfuls of calcined magnesia daily, passed with the greatest difficulty numerous intestinal concretions, which were very hard, and consisted almost wholly of magnesia. Dr. H. Guéneau de Mussy had a lady under his care in whom, consequent on the abuse of magnesia, a calculus was formed, and caused complete intestinal obstruction, and had to be removed by means of a mallet and chisel. He also knew of a case in which death was caused by a similar calculus. It is evident, therefore, that this remedy, which is usually regarded as quite inoffensive, may give rise to grave disorder when used in excess.—*Med. Times and Gaz.*, Aug. 23, 1879.

Effects of the Electric Light on Vision.—A series of researches recently pursued by Prof. Cohn, of the Breslau University (*St. Petersburgh Med. Woch.*, June 21), has led to some important conclusions. The recognition of letters, points, and, above all, colours takes place at much greater distances in electric light than in either gas or daylight. The perception of yellow is multiplied sixtyfold, that of red sixfold, and green and blue are each doubled in perceptibility. The letters of Snellen's types are increased from 1 to 1.2 and 1.5, and Burchardt's points from 1 to 2; while eyes that have the colour sense weak and acuteness of vision but slight in gas and daylight, undergo varying improvement in the electric light.—*Med. Times and Gaz.*, July 12, 1879.

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The Telephone and Diseases of the Ear.—The introduction of new inventions amongst the practical requirements of civilized life brings with it its disadvantages. The telephone is destined to become a most useful agent in daily intercourse; but Dr. F. M. Peirce, of Manchester, points out (*Brit. Med. Journ.*, Aug. 2, 1879) a possible source of inconvenience in its use. The following case which came under his notice exhibits a way in which the ear may be more or less injured during the use of the telephone.

A woman, about thirty-five years of age, manageress at a smallware manufactory in Manchester, which was connected with its office (two miles off) by a telephone, was listening to a message, when a violent clap of thunder took place, and which appeared to be conveyed through the wire. The effect on the listening ear was that of complete numbness and deafness, accompanied by a sensation of giddiness, slight nausea, and tinnitus aurium. These symptoms, with the exception of the deafness, passed away in a few minutes. Dr. P. did not see the patient for three or four days after this occurrence, and cannot, of course, speak as to the amount of deafness at first produced; but on the fourth day, he examined the left ear (the listening ear), and found the hearing distance twenty-forty-eighths of an inch. As his patient had always had perfect hearing with both ears, and had never experienced any difficulty in hearing before, he thinks it very unlikely that this degree of deafness was due to any previous affection of the ear. She stated that she had never had anything the matter with her hearing until using the telephone during the storm. He has examined her lately, and found both ears and hearing distance quite normal; nearly a fortnight elapsed, however, before perfect hearing returned. This case was no doubt due to a concussion of the auditory nerve.

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A Rare Lesion.—At a meeting of psychologists in Heidelberg, Professor Friedreich presented a patient who had been for the last three and a quarter years subject to clonic convulsions of the lips, the tongue, and the maxillary muscles. The lips were thrust forward, the tongue was rolled about in the mouth, the jaws opened and shut with great force, so that the tongue was fearfully bitten. These convulsions continued even while the patient was asleep. The right pupil was enlarged; the pulse quick and somewhat irregular. Professor Friedreich thought that these convulsions were caused by a circumscribed lesion of the medulla oblongata. —*British Med. Journal*, July 19, 1879.

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The Effect of Smoking upon the Teeth.—At a recent meeting of the Odontological Society of Great Britain, Mr. Hepburn read a paper on this subject; and the results of his investigations on the subject are contrary to what is, we believe, the popular notion. He considers that the direct action of nicotine upon the teeth is decidedly beneficial. The alkalinity of the smoke must necessarily neutralize any acid secretion which may be present in the oral cavity, and the antiseptic property of the nicotine tends to arrest putrefactive changes in carious cavities. In addition, he is inclined to believe that the dark deposit on the teeth of some habitual smokers is largely composed of the carbon with which tobacco smoke is impregnated. It is this carbon which is deposited upon the back part of the throat and lining membrane of the bronchial tubes; and with whatever disastrous effect it may act in these situations, he thinks we are justified, from what we know of its antiseptic properties, in concluding that its action upon the teeth must be beneficial. Moreover, this deposit takes place exactly in those positions where caries is most likely to arise, and on those surfaces of the teeth which escape the ordinary cleansing action of the brush. It is found interstitially, in all minute depressions, and filling the fissures on the coronal surfaces. It may be removed with scaling instruments from the surface of the enamel, but where it is deposited on dentine, this structure becomes impregnated and stained. Indeed, it is only where the enamel is faulty, and there is access to the dentine, that any true discoloration of the tooth takes place; but it is remarkable, he says, how the stain will penetrate through even minute cracks provided the necessary attention to cleanliness be not exercised. The staining power of tobacco-oil may be seen when a deposit has taken place on the porous surface of tartar collected on the posterior surface of the inferior incisors. In this situation a shiny ebony appearance is occasionally produced. That tobacco is capable of allaying, to some extent, the pain of toothache is, he thinks, true; its effect being due, not only to its narcotizing power, but also to its direct action upon the exposed nerve; and he is inclined to attribute the fact of the comparatively rare occurrence of toothache amongst sailors, in great measure, to their habit of chewing. He has been struck, in the case of one or two confirmed smokers who have come under his notice, by the apparent tendency which exists towards the gradual production of complete necrosis of carious teeth, and the various stages of death of the pulp and death of the periosteum taking place without pain or discomfort to the patient. This condition may, of course, be brought about by a variety of influences; but in these special cases he is inclined to think that the presence of nicotine in the mouth has acted powerfully. The experience of other speakers in the subsequent discussion appeared to corroborate that of Mr. Hepburn, except that Mr. Oakley Coles thought the frequent changes of temperature probably injurious and tending to produce cracking of the enamel, and Mr. Arthur Underwood thought that smoking to the extent of injury to digestion tended to cause recession of the gums and otherwise to injure the nutrition of the teeth.—*British Med. Journal*, July 5, 1879.

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A Nuisance by Noise Restrained.—The appeal from the Master of the Rolls in the interesting case of noise nuisance reported in the MEDICAL NEWS for August, 1878, p. 139, was recently heard, and judgment for the plaintiff was affirmed. It will be remembered that the defendant, a confectioner, had two large mortars fixed in the brickwork against his kitchen wall, the mortars being worked with heavy iron pestles. This kitchen wall also formed the boundary wall of the garden behind the plaintiff's (physician's) house. These pestles and mortars had been in constant use on the defendant's premises for upwards of twenty years. The plaintiff, having lately built out a consulting-room abutting on the boundary wall of his garden, found the noise and vibration in the room caused by the use of the pestles so great, that he brought this action to restrain the nuisance. The Court below held that the easement or right claimed by the defendant was not one which could be acquired under the statute, or by prescription, and granted an injunction. The defendant appealed; but their lordships dismissed the appeal with costs.—*Med. Times and Gazette*, Aug. 9, 1879.

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Colour-Blindness. — Nothing would be more unwelcome than an abatement of the public interest in the occurrence of colour-blindness among the *employés* of railway companies, pilots, sailors, and others who have to do with coloured signals; but caution is necessary lest zeal outrun prudence. In the eagerness to weed out all persons afflicted with any form of colour-blindness there is a risk of rejecting some otherwise eligible candidates merely because they are unable to *name* the particular colours employed as tests. This is not colour-blindness in the proper sense of the term, and need not, of itself, be a disqualification. For all practical purposes the defect may be said to consist in either a total inability to *recognize* certain colours, or in an extreme slowness or uncertainty in discriminating colours that are essentially different. Failing to name a colour may merely signify want of acquaintance or familiarity with colour-epithets. Many persons who call all shades of a colour, and even widely different colours, by the same name, when asked to sort out coloured objects, are found to possess an acute colour-sense. They have only a deficient vocabulary. There is another not uncommon form of false colour-blindness which has been lately brought into prominence through a correspondence in *The Times.* From want of proper training of the retinal elements for colour impressions an individual may, even with healthy eyes, be unable, at first, to distinguish different colours. Like a person who has not learned the alphabet, he fails to recognize the special peculiarities and distinguishing marks of the objects under examination; or, to use Dr. Stone's simile, he is like a person with a "bad ear" for music; the special sense-organ is untrained. In the absence of organical defect, this condition is removable by education and practice. It is, however, very desirable that the education and practice should precede, not follow, the instalment into responsible posts, the proper discharge of which involves the safety of life and property. The public mind cannot be satisfied until it is assured that all applicants for such posts are submitted to strict examination by competent authorities.—*Lancet*. Aug 20, 1879.

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OBITUARY RECORD.—At Versailles, on the 26th of August, aged 74, E. CHASSAIGNAC.

M. Chassaignac was a bold and skilful operator, and the inventor of many ingenious instruments and procedures. His various improvements in practical surgery, chief of which are linear écrasement and surgical drainage, have given him a prominent place among the great surgeons of his generation.

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VOL. XXXVII. NOVEMBER, 1879. No. 443.

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CLINICAL LECTURES.

ON PROLAPSE OF THE OVARIES.

A Clinical Lecture delivered at the Hospital of the University of Pennsylvania.

BY WILLIAM GOODELL, M.D.,
Professor of Clinical Gynæcology in the University of Pennsylvania.

GENTLEMEN: On either side of the womb are two small glands, in size and shape very like almonds. They secrete the ova and are, accordingly, called ovaries, and they preside over the individuality of woman as much as the testes do that of man. Very important organs they, therefore, are, and as such are largely supplied with nerves and blood-vessels. Each one is moored to the womb by a special ligament, and each one lies loosely in a fold of the broad ligament. But, like that of a ship riding at anchor, their position is an unstable one, and they freely play about the womb as their centre of motion. Still, Nature being the best of stevedores, the abdominal cavity is, through her care, so intelligently packed, and its retentive power made so great, that these loosely attached bodies, except through disease, hardly ever become permanently dislocated. Their true position is high up on either side of the fundus of the womb, out of harm's way from the impact of the male organ, and beyond reach of even the examining finger. An

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ovary in its healthy state cannot indeed be ordinarily made out by either suprapubic palpation, or by a vaginal examination, or even by both conjointly.

They have, however, a knack of getting into strange places, and when one plays truant, its fellow is very likely to follow. One ovary has repeatedly been found in the sac of an inguinal hernia, and, if the hernia happens to be double, each ovary will then go astray. One will lodge in the sac of a femoral hernia, and even in that of an umbilical hernia. I found one once in the right labium majus of a young married woman, who was sterile, and once in an old lady of ninety, I felt one in the sac formed by an inverted vagina. When in such abnormal situations, the ovaries usually degenerate, and the woman, like a cryptorchis, is unable to procreate.

At every monthly period the ovaries become turgid with blood, and sink low down from their weight. They can then be often felt and even outlined in Douglas's pouch. When this congestive period is over, they rid themselves of their overfreight of blood, and again float up out of reach. Unfortunately, however, they will sometimes stay turgid, and, consequently, become permanently dislocated. Accompanying this dislocation, there will generally be some uterine lesion, which will stand in the relation either of cause or of effect. Nor could it very well be otherwise, for very close is the vascular and nervous kinship between the two—so close, indeed, that turgidity in the one means erectility in the other. Hence it is not always easy to decide which lesion was primary, and which is secondary.

Any cause, then, tending to a lasting congestion of the reproductive apparatus, is very likely to lead to a prolapse of the ovaries. A torn cervix, an arrest of involution after labor, any backward displacement of the womb will do this. You will frequently find this lesion in barren women. The relation here between cause and effect, is obviously this: In sterile women, the lack of pregnancy and of suckling prevents that much needed break in the constantly recurring catamenia, and the physiological congestions of the womb, augmented by the sexual congestions, are by ceaseless repetition liable to become pathological. Perverted sexual relations and perverted sexual excitations, are by no means rare causes of this trouble. For instance, I have repeatedly discovered the ovaries low down in women who were shirking maternity. Here an over-stimulation of the whole reproductive apparatus is kept up both by the enforced sterility and by some of the preventive measures employed, which awaken the sexual instinct without appeasing it. So repeated erectility from self-abuse, by ending in a passive congestion of the womb and of the ovaries, tends to these dislocations. The prevalence of this habit in girls is, I think, very much overrated, and yet I have seen several cases of prolapse of the ovaries from this cause. In one, the ectropion of the cervical mucosa was so marked, that it leads me to think that I had discovered the cause of the occasional inversion of the womb in virgins. My note-book shows cases of ovarian prolapse from such imperfect sexual relations as come from the ill-health or the greater age of the husband, and not a few from excessive intercourse. Finally, in thin and unhealthy women of lax fibre, there is an absence of the pelvic padding of fat, and an impairment of the retentive power of the abdomen. Then, again, they lose an erect carriage, and their spine becomes bow-shaped. The pelvis, departing from its natural obliquity, comes to lie more at a right angle to the spine, and the axis of the upper strait, instead of striking a point in the linea alba below the navel, tends now to coincide with that of the trunk. As a result the intestines crowd down into the pelvis and displace the womb and the ovaries.

When one ovary becomes displaced, it is usually the left one. It then lodges more or less low down in Douglas's pouch, and gives rise to a world of trouble. This brings us to the symptoms. First and foremost, is pain in locomotion. As the ovary now lies between the womb and the sacrum, it gets pinched between them at every step. This pain is of a sickening and an unnerving character, and often runs down the corresponding thigh, along the track of the genito-crural nerve. One of my patient's will, while walking, be suddenly seized with such a pain which either momentarily cripples her, or lasts so long as to compel her to return home at once in a car. Her left ovary behaves like a loose cartilage in the knee-joint, and has, for some reason, slipped down so low as to get nipped. She always gets relief by putting herself on her knees and breast, a postural method which I shall shortly describe to you. A second symptom is a throbbing pain while the rectum is loaded, and an agonizing pain during defecation. This arises from the grating of the hardened feces over these tender glands. A third one, is painful coition, for the ovaries are now so low down as to be hit by the male organ. A fourth, is gusts of pain radiating from one groin. Another very common symptom is a morbid state of the mind, accompanied by low spirits. As a man with any trouble in his testes is in the slough of despond, so will a woman be when her ovaries are turgid and dislocated. The psychical sphere of man and woman seems to be conditioned very much by the sexual sphere.

I now come to the diagnosis, but this we shall study in the living subject, for then it will be better impressed on your memories. I shall now bring in a patient, who, for obvious reasons, has been kept in the waiting-room until this moment.

She is a short woman, with an unusually broad pelvis, aged thirty-five. She dates her illness from her last labor, which took place some three years ago. Her symptoms are low spirits, crippled locomotion, and such pain during the act of defecation that I was misled into the belief that she had an anal fissure. In addition to these, she complains of menorrhagia, of dysmenorrhœa, and of the usual symptoms betokening uterine trouble. The conjugal relations are painful, but not wholly interfered with. The cervix is torn, the womb bulky, and its body bent acutely backward. The sound gives a measurement of plus three inches. These are facts which I gained a week ago by a careful examination, and I shall not take up your time by verifying them. Suffice it to say, they denote arrested involution after her last labor. What I wish now to impress upon you is the mode of discovering the ovaries when prolapsed. As my index finger reaches the *cul-de-sac* of the vagina, it is arrested by a small tumor, which is quite tender. This I can trace directly into the cervix, and, therefore, I know it to be the retroflexed body of the womb. But on each side of it my finger discovers two smaller bodies. One of them lies so low down that it can be outlined. The other is higher up, but still a definite idea can be gained of its form, which is a flat ovoid The slightest pressure on each of these bodies makes the woman flinch. But now comes the crucial test, as I press either one against the sacrum, the woman complains of what she calls a "sickening pain." Now, should I increase the pressure and make one of these bodies slip suddenly away from under my finger, as boys let fly a cherry-stone, such a thrill of indescribable pain would dart through her groin and down the inside of the corresponding thigh, that she would scream out and become deathly sick. It is that peculiar pain which all of you have felt when a blow has been received on analogous organs. I shall not, however, subject her to this ordeal, for I am quite satisfied with my diagnosis. The position of these bodies, and the character of the pain elicited from them, tells the whole story, for no other organ but an ovary can give such a history.

Well, the diagnosis having been established, how shall we treat this woman? As far as medicines are concerned, we must choose those which lessen the engorgement of the reproductive organs. I shall, therefore, prescribe thirty grains of potassic bromide, and ten drops of the tincture of digitalis, to be taken thrice daily in a tablespoonful of the compound infusion of gentian. Each of these medicines is a trustworthy anaphrodisiac, and will effectually quench all erectility of these organs. After a couple of weeks, alteratives may come into play, and she will then be put on the use of my favourites—the ammonic chloride and the mercuric bichloride. They can be advantageously administered after the following formula:—

℞.—Hydrargyri chloridi corrosivi, gr. j.
Ammonii chloridi, ʒij.
Mist. Glycyrrhizæ co., f℥vi. M.

S. One tablespoonful after each meal, in a wineglassful of water.

The paregoric in this mixture helps to control the aches, the antimony adds its quota to the needed alterative action, and the licorice disguises the harsh taste of the ammonic chloride. Another very excellent alterative and nervine is the auric and sodic chloride. This I shall hold in reserve to fall back upon, should no response come from the mixture. It will be made into a pill, and given after each meal in increasing doses, beginning with one-eighth of a grain and not exceeding one-quarter of a grain. Conjoined with this treatment, such a local one should be addressed to the womb as tends to lessen its engorgement, and, thereby, the ovarian congestion. Among the best are scarification, douches of hot water, iodized phenol, and vaginal suppositories of iodoform and of belladonna.

Pessaries are important adjuvants in all cases in which the womb is retroverted or is retroflexed. But in the simple, uncomplicated cases of ovarian prolapse, they usually do more harm than good. To be of service in keeping up the ovaries, a pessary must be long enough to obliterate Douglas's pouch, and the pressure on the sacral nerves then becomes unbearable. If, on the other hand, it be too short, the ovaries slip down behind it and get badly pinched. These requirements practically exclude the resort to a Hodge pessary, or to any of its modifications. Of hard rubber pessaries, Cutter's bulb is the best. It offers a broad shelf on which the ovaries will sometimes, but not always, lodge. In the long run, I have found Hoffman's air cushion to answer the purpose better than any other; but then, it becomes fetid and soon collapses. Now, by a piece of good luck, I find that a thick and an elastic ring-pessary helps my patient very much, so I shall let well enough alone, and stick to it.

A very excellent way of keeping up the ovaries, one which in every case I adopt, and one which I shall now teach this patient, is the knee-breast posture devised by Dr. C. F. Campbell, of Georgia. Two or three times a day, or more frequently if needful, this woman will unhook her dress, loosen her underclothing, and kneel on her bed as she now kneels on this table. Her body is then bent forward until the breast is brought down to the surface of the bed, while her head is turned to one side and supported in the palm of her left hand. Her knees should be about ten inches apart, and the thighs perpendicular to the bed. If she now refrains from straining, and breathes naturally, a reversal of gravity will be established. With the fingers of her free hand she will next open her vulva. Air will rush in, and the abdomen and its contents will at once sag down. This will, of course, draw up the womb and the displaced ovaries out of the pelvic canal. As it is rather awkward for a woman, while in this posture, to free one hand and reach the vulva, Dr. Campbell advises that, previously to taking this attitude, she should insert into the vagina a small glass-tube open at both ends, and long enough to project externally. This will leave an air-way, and dispense with the use of the fingers. With such tubes as I now show you, I furnish each one of my patients, but you will find a good substitute in the empty barrel of the old-fashioned cylindrical "female syringe," as it is called. After staying in this posture for a few minutes, the woman will remove the tube, and slowly turn over on her side, where she will lie as long as she can. Such constant replacements are of great service, for they lessen the throbbing, they give the limp ligaments a chance of shrinking, and they teach the ovaries good habits of staying at home.

With so intractable a disorder as this one needs to have every possible therapeutic device at one's finger-ends. So put down in your note-books abdominal braces as another mode of treatment. A brace of this kind may not cure, but it will often blunt the edge of the aches, and, to that extent, gives much comfort. You will naturally ask the rationale of its action. It is this: By pressing the abdominal wall upward and inward the brace forms a shelf on which the viscera rest, and thus takes off a portion of the load from the womb and its ovaries. By virtually narrowing the pelvic aperture, it lessens the space into which the viscera tend to crowd, and, to that extent, protects the pelvic organs. By swinging the pelvis backward, it makes the axis of the upper strait lie more obliquely to the axis of the trunk, and the sum of the visceral pressure now converges, not in the pelvic basin, but on the portion of the abdominal wall lying between the symphysis pubis and the umbilicus.

There is yet another treatment, which, when combined with the knee-breast posture, I deem the best of all, for with it I have been very lucky. It is the treatment devised by my friend, Dr. S. Weir Mitchell, which consists of rest in bed, massage, electricity, and forced feeding. After the patient begins to improve and to fatten up, as she usually does under this treatment, the ovaries are daily replaced by atmospheric pressure, and the result is that they finally go up to stay up. Why is this so? Because, by massage and electricity, the circulation of blood and of nerve-fluid is equalized, and the ovaries are relieved of their turgescence. They become lighter. Then, the increased deposit of fat in the abdominal walls, in the omental apron, and around the viscera, to say nothing of the needful fat-padding in all the pelvic nooks and crannies, increases the retentive power of the abdomen. But there is yet another explanation for this ascent of the ovaries. The gravity of the now fat-laden and overhanging wall of the abdomen, tends to draw toward itself—that is to say, upward—the movable floor of the pelvis. The behavior is like that of a half-filled rubber ball, in which bulging at one portion causes a corresponding cupping at another. This explains the ascent of the womb in women who get fat after the climacteric.

Once in a while, however, such lasting tissue-changes take place in the ovaries as no medication can reach. The hypertrophied glands keep heavy and refuse to float up. Now, must the unfortunate owner of these organs drag out the rest of her menstrual life, burdened with the distressing ovaralgia, the crippled locomotion, and with all those aches, and pains, and throbs which I have described to you? No, indeed! The source of all this mischief, the ovaries themselves, must be removed. Nor need you fear that such an operation will unsex a woman. In the cases in which it has been performed by myself and by others, it in no wise changed the voice, the appearance, or the character of the woman. It merely brought on, more abruptly than nature does, that change of life which every woman longs to reach, and which, while taking away all hope of future offspring, makes her no less a mother or a wife.

HOSPITAL NOTES AND GLEANINGS.

Case of Poisoning by Hydrate of Chloral.—E. T., aged forty, civil engineer, was admitted into St. Thomas's Hospital, under the care of Dr. Stone, July 2d. The patient had been found in the comatose condition on the afternoon of the day of admission, at a coffee-house where he had slept the previous night. He had swallowed fifteen drachms of the officinal syrup of chloral, containing 150 grains of chloral. The remainder, contained in a labelled six-ounce vial, enabled the quantity to be easily measured. The exact time of taking the dose was not known.

On admission, he was in a state of partial coma attended by considerable collapse. The breathing was laboured, the face was flushed, and there was nearly complete insensibility of the conjunctivæ; the pupils were rather contracted, and the extremities blue and very cold. The contents of the stomach, which were of a light yellow colour, were at once evacuated by the stomach-pump. He occasionally moved his hands, but showed few signs of consciousness beyond this. He objected to medicine, and spat out part of it. The temperature was 98.6°; pulse 108, very feeble and compressible; cardiac impulse insensible; respirations 36. Four hours afterwards the temperature was 100.6°: the pulse 108 and stronger; the respirations 42. The cardiac impulse, which was previously scarcely perceptible, was readily to be felt.

July 3. Temperature 99°; pulse 108, very feeble and compressible; respirations 28; face flushed, pupils contracted, hands cold; rather restless, tossing about in bed and occasionally trying to get up; fairly sensible; perfectly rational, answering in monosyllables. No disease of any organ was detected on examination.

4th. Drowsy, but answering rationally; careful not to commit himself to any damaging statement, and probably telling falsehoods. Pupils sluggish, but act well after excitement. Pulse feeble, rapid, and readily accelerated after excitement, rising to about 128; respirations 32, not stertorous. Distinct sweet odour of breath, resembling that of chloroform. The urine was passed involuntarily at first, but afterwards consciously. The hands are cold, the feet fairly warm. No fulness of jugulars, no pulsation of carotids, no spasm, and no paralysis.

The patient recovered without further symptoms. His recovery was, however, retarded by two small blisters on the feet, which suppurated, and by a red, brawny, circumscribed patch on the right buttock. Of these injuries he could or would give no account; they were probably burns and a bruise of accidental nature, self-inflicted during a condition of drunkenness. There was no evidence of suicidal intent. The treatment consisted chiefly of stimulants, half an ounce of brandy with small quantities of ammonia and ether being given every two hours at first, and then gradually reduced in quantity. Mustard-poultices were applied to the calves and præcordial region. The bowels were freely opened by ol. crotonis ♏ij. The chief points to be noticed in the cases were (1) the large and accurately ascertained dose; (2) the very considerable variation from the symptoms of chloral poisoning as recorded by Dr. Oscar Liebreich, especially in respect of lowered temperature, slow respiration, and the state of the pupils. (3) The absence of any delirium or mental disturbance; his answers, even during the comatose stage, being not only rational, but cautious and deliberate.—*Med. Times and Gazette*, Sept. 6, 1879.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Self-Limitation in Cases of Phthisis.—At a recent meeting of the New York Academy of Medicine (*Med. Record*, July 19, 1879), Dr. AUSTIN FLINT read a suggestive and interesting paper upon the above subject. It was more than forty years since Jacob Bigelow applied the term "self-limited" to certain diseases, and gave to it the following definition: "By a 'self-limited' (disease) I mean one which receives limits from its own nature, and not from foreign influences, which, after obtaining a foothold in the system, cannot, in the present state of our knowledge, be eradicated or abridged by art, but to which there is due a succession of processes to be completed after a certain time; which processes and time may vary with the constitution of the patient, and may tend to recovery or to death, but are not known to be shortened or greatly changed by medical treatment."

Since the publication of that discourse a host of diseases had been shown to be self-limited, but especially the essential fevers, inclusive of acute pneumonia, and many acute inflammations. By observations made in 1863, Dr. Flint proved that acute articular rheumatism, and also in 1875, that acute dysentery, belonged to that category.

It was interesting to inquire, in different diseases and in different cases of the same disease, how far the course and termination might be due to self-limitation. The object of this paper was to inquire how far the favourable course and ending of pneumonic phthisis were determined by self-limitation. So long ago as 1858, he published a paper in the *American Journal of the Medical Sciences* in which it was claimed that pulmonary phthisis might be self-limited, and an analysis was given of twenty-four cases which had terminated in recovery.

That claim had been renewed in 1863, in a paper that appeared in the published Transactions of the New York Academy of Medicine, and it had since been reiterated in his work upon the Practice of

Medicine, and more recently in his work upon Phthisis. Of all diseases, phthisis was the least expected to end favourably from intrinsic tendency. The cessation of its progress was considered as implying some extrinsic agency by means of which it had been arrested.

Things necessary to be established.—Dr. Flint inquired, What was necessary to establish the fact of a favourable course, and to prove of any other disease that its favourable course and termination were due to self-limitation? A disease belonged in that class when it ended in recovery independent of hygienic or therapeutics; in other words, when the favourable course, and termination were due to intrinsic tendency, even though they were promoted by judicious treatment. On the other hand, a favourable intrinsic tendency might be obstructed by injudicious treatment.

Self-limitation could not be inferred from a single case, or a few cases, because the course and termination of disease might be affected by influences which were extrinsic, but not apparent. The cases observed, therefore, must be large. They must be carefully and honestly observed. There must be no room for doubt with regard to the accuracy of diagnosis. At once the difficulties became obvious which prevented the requisite study and observation, and the cases in which the requisite conditions were fulfilled were rare. But during a period of thirty-four years Dr. Flint had observed the histories of a number which he believed to be amply sufficient to establish the statement that—

In certain cases pneumonic phthisis, or pulmonary consumption, ceased to be progressive and might end in recovery from self-limitation.—He had not included acute tuberculosis under that head, and had also excluded the disease known as interstitial pneumonia or fibroid phthisis. He should consider the term pneumonic phthisis as applicable to all cases of phthisical disease exclusive of acute tuberculosis and interstitial pneumonia.

Of 670 cases of phthisis, the list embracing a few cases of acute tuberculosis and interstitial pneumonia, 44 ended in recovery. In 31 cases the disease ceased to progress, remained non-progressive for several months, and in a majority of the cases for many years. In 31 cases the phthisical disease might be considered as having ended, complete recovery not taking place. Those 31 cases he regarded as hardly less valuable in the study than those which terminated in recovery. In 75 cases, therefore, there was either recovery from phthisis or the disease ceased to progress.

Such a collection of cases offered a rich field with reference to several points of inquiry; but only one was taken up, namely, the proof of self-limitation.

In how many of the cases was it evident from the history that the cessation of the disease was not due, and its progress not arrested by medicinal or hygienic treatment? Answer to that question furnished proof of self-limitation.

Medicinal Treatment.—Of the 44 cases which ended in recovery, there were 23 in which there was no medicinal treatment to which arrest of the disease could be attributed. In the remainder of the cases medicinal treatment consisted in the use of simple tonics, but in none of them could the treatment be considered curative.

Of the 31 cases in which the disease was non-progressive without recovery, there were 15 in which there was no medication by which the disease was controlled, and in several none whatever.

In the two groups of cases, namely, those ending in recovery and those in which the disease was non-progressive, medicinal treatment was absent in about equal proportion; in the first group, 23 of 44; and in the second group, 15 of 31.

Hygienic Treatment—In a considerable proportion of cases change in climate and other hygienic measures were not of such a character that potential influence could be attributed thereto.

Dr. Flint then referred to cases already published in his work on Phthisis, the histories of which he claimed established self-limitation in cases of phthisis.

He was unable to quote any authors who declared in distinct terms that phthisis was a self-limited disease. The *curability* of phthisis, however, was by no means a novel doctrine. All observers of much experience agreed that patients had recovered from pulmonary phthisis even after the formation of cavities, but in all those instances the disease had been supposed to be cured sometimes by medicinal, sometimes by hygienic treatment, or by both combined. The position had not been taken by others that the recovery was spontaneous in some of those instances.

Dr. Flint's *first* object was to show that he had been warranted by facts in taking the position that self-limitation, in cases of phthisis, was established.

His *second* object was to speak of self-limitation as bearing upon conclusions drawn with respect to the treatment of phthisis. If the disease ended in recovery, exclusively from intrinsic tendency, it was evident that self-limitation must be more or less concerned in cases in which recovery took place under different measures of treatment; that it was a factor co-working with certain measures. When that factor was feeble or wanting, curative treatment would not probably be of much avail. Allowance must be made for that factor in estimating the value of curative treatment. The extent of its working must be different in different cases; sometimes considerable, sometimes moderate, and sometimes slight. Recovery from phthisis, in order to become proof of the success of any method of treatment, must take place in a number of instances, so large as to render it certain that the real agency could not have been self-limitation. It would be unjust to say that therapeutics were powerless, because when combined with self-limitation they would probably save many cases which would not otherwise recover.

Change of Climate.—Dr. Flint regarded change of climate as a most important measure in the early stage of the disease. With reference to the part of the world best suited for consumptive patients, experience was discrepant. He then referred to two patients who visited Nice; one was loud in praise of that locality for consumptives, and the other was equally energetic in disparagement of Nice. Self-limitation in one was effective, in the other it was wanting. The only scientific plan of investigation respecting changes of climate was to study results in a considerable number of cases. Dr. Flint then made an analysis of 74 cases in which temporary change of climate was an important, and in some the chief measure of treatment. Of the 74 cases, 9 ended in recovery, and in 13 the disease was non-progressive. 22 out of 74 cases were regarded as a number sufficiently large to warrant the conclusion that more or less curative influence was due to climate. To those were added other cases in which the disease was slowly progressive, and in only 11 of the 74 cases did it appear that there was no improvement following change of climate.

One of the most striking recoveries took place in New York City, and without any important medication.

The inquiry with regard to the best place for consumptives was important, but for lack of time it was essentially waived with the remark that the selection of the resort must be governed by the circumstances proper to each case. The same remark was applicable to other hygienic measures. An important point in the clinical study of phthisis, with reference to effect produced by change of climate and hygienic measures, was to make a correct estimate of the influence of self-limitation in determining a favourable course of the disease.

Third. Dr. Flint offered some remarks with regard to symptoms and signs by means of which judgment must be formed with reference to the influence of self-limitation in individual cases of phthisis. Was it possible to judge whether there was an intrinsic tendency to a favourable course and termination? The symptoms which warranted hope, sometimes even an expectation of a favourable course and termination, related especially to the circulation, to body heat, to alimentation, and to nutrition. Persistent frequency of pulse, fever, anorexia, and progressive emaciation, opposed reliance on self-limitation. In proportion as phthisis was well tolerated, there was room for hoping that the disease would prove self-limited. If tolerance was limited, self-limitation was proportionately weak or wanting. There were abortive cases of phthisis as well as of other diseases, evidenced by phthisical lesions found at the apex of a lung post mortem, without clinical history. Self-limitation might be exemplified, notwithstanding a large area of consolidation followed by cavities of considerable size. Confinement of the affection within circumscribed limits, that is, an absence of signs indicating progressive extension and general diffusion, were the most reliable points for a favourable prognosis. Heredity was not incompatible with an intrinsic tendency to recovery, and reference was made to an illustrative case in which both parents, three sisters, and three brothers died of phthisis.

In conclusion, Dr. Flint remarked that his histories afforded proof that profuse and repeatedly occurring hæmoptysis, chronic laryngitis, pleurisy with effusion, and perineal fistula, were not by any means in all cases unfavourable with regard to prognosis based upon self-limitation.

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The New Library Hall of the New York Academy of Medicine.—The new library hall of the New York Academy of Medicine, No. 12 West Thirty-First Street, was formally dedicated on the evening of October 2d, in the presence of a large audience. The new hall measures 28 feet in width by 50 feet in length, and is two stories in height. It forms an extension to the building which was purchased by the Society some four years ago, at a cost of $42,500, and which they have already found to be too small for their purposes. The entire lot of 128 feet in depth is now covered by the combined structures. The first floor of the hall has been fitted up as a lecture room, and can accommodate 200 persons. The ceiling is lofty, having been carried up to the height of the third floor, a wide gallery extends around all four sides of the room, and communicates with the second floor of the main building through a wide archway, and affords shelf-room for the larger portion of the Academy's library. The most approved methods of ventilation have been adopted. In the centre of the ceiling is a large double skylight, with a space between the upper and lower sashes of about five feet. The lower sash bears the coat of arms of the Society, beautifully finished in coloured glass. Around this lower sash is a space about six inches wide, just beneath which a border of gas jets, sixty-four in number, is placed. By means of this arrangement the room is lighted, and, the flames producing a current of air, the hot, foul air of the room rushes upward and outward through the upper skylight, while its place is supplied by fresh air admitted through ventilators near the floor. A black marble tablet set in the wall at the head of the room bears the following inscription in letters of gold: "This hall, the gift of Abram DuBois, M.D., generous benefactor of the New York Academy of Medicine, was erected A. D. 1879."

The walls of the hall were adorned with a very valuable and interesting loan collection of portraits of local medical celebrities, mostly of by-gone days.

Dr. Fordyce Barker, President of the Academy, opened the proceedings with an address, chiefly historical, and in conclusion he unveiled and presented to the Academy a beautiful marble bust of Mr. Spencer Wells, which was cut by Professor Liebreich, the distinguished London ophthalmologist, and was greatly admired at the last exhibition of the Royal Academy. Addresses were also made by Prof. Acland, of the University of Oxford; by Prof Gross, of Philadelphia; Dr. Billings, U. S. A., Librarian of the National Medical Library; Dr. Shattuck, of Boston; Dr. Willard Parker and Dr. Austin Flint, of New York. After the addresses, the company was invited to partake of a collation generously provided by Dr. Barker.

The Academy has a mortgage debt of $10,000. Its library contains about ten thousand volumes, and regularly receives about seventy-five current American and foreign medical periodicals and records of medical and other learned societies. Its collection of early American journals is very valuable, and was the gift of Dr. Samuel S. Purple.

American Public Health Association.—The next meeting of this Association will be held at Nashville, on the 18th to the 21st of November, and it is announced that there will be a discussion on the practical questions connected with the management of an actual or threatened outbreak of yellow fever. The discussion will be prefaced by the reading of several papers by members of the Association who have been actively engaged in this practical work during the prevalence of the existing epidemic in Memphis and elsewhere.

In order to give definite directions to the discussion the executive committee has adopted the following schedule of the points to be especially considered:—

1. How to deal with a city in the yellow-fever zone in order to prevent the appearance of a first case.

2. How to prevent the importation of a first case.

3. How to deal with a first case and early cases generally when, in spite of precautions under first and second headings, it has made its appearance.

4. The duty of local boards of health, or other health authorities to report such cases promptly, even though there may be some doubt as to the diagnosis. Whether the knowledge that such reports would be faithfully made would not have a tendency to allay apprehensions and give confidence to other communities while warning them of the importance of making preparations for contingencies.

5. Under what circumstances may it become necessary or expedient to remove the unacclimated portion of the population from an infected place? How may this be effected for the poorer classes of the population, and how should the people thus removed be cared for and supported.

6. Measures for isolating a dangerously infected place.

7. Organizations for the relief and treatment of the sick in an infected city.

8. Measures for preventing the spread of the disease from an infected place by railroads, including the management of transfer stations.

9. Inspection of steamboats at an infected place and at intermediate stations between the port of departure and their final destination. Should stations of observation be established by the National Board of Health? If so, what should be their relations to the health authorities of the States within whose territorial limits they may be established?

10. Results of the co-operation and aid given by the National Board of Health to State and municipal boards under the provisions of the Act approved June 2, 1879. What suggestions may be made to render this system more efficient?

OBITUARY RECORD.—At Cincinnati, on the 15th of August, MARMADUKE B. WRIGHT, M.D., Emeritus Professor of Obstetrics in the Medical College of Ohio, and Consulting Obstetrician to the Cincinnati Hospital.

Dr. Wright was an accomplished obstetrician; he was bold in conception, fertile in resource, and skilful in operation. His claims to the discovery of cephalic version by combined external and internal manipulation are now generally admitted. He was a good teacher, a successful practitioner, and a useful citizen.

—— at Cincinnati, on the --th of October, aged 61, JAMES GRAHAM, M.D., Emeritus Professor of the Practice of Medicine in the Medical College of Ohio.

Dr. Graham was born in New Lisbon, Ohio, in 1818, and graduated in Medicine at the University of Pennsylvania. He was elected to the Professorship of Practice in the Medical College of Ohio in 1854, and held the position for twenty years. He was a gifted teacher, a keen diagnostician, a skilful practitioner, and a reliable consultant. He enjoyed in a singular degree the confidence and affection of his patients, and the respect and esteem of his associates.

FOREIGN INTELLIGENCE.

Signs of Death by Drowning.—MM. BERGERON and MONTANO (*Annal. d'Hygiene*) have arrived at the following conclusions on the subject of death by drowning: 1. The presence of frothy foam, not only in the pharynx and larynx, but also in the bronchi, is the constant sign of death by submersion, whether syncope or asphyxia predominated in the mode of death, and whether the individual was free in his movements or was thrown into the water after having been made insensible by opium or chloroform, or was partly suffocated, or was fettered in his action. This absolute constancy of the presence of foam, whatever the special condition in which the submersion occurred, is, in the opinion of the authors, the single sure uniform sign proving death by drowning. 2. There is always a certain degree of congestion, and sometimes subpleural ecchymoses are seen; but these ecchymoses, which give the lungs a spotted or speckled look, are unlike the punctate ecchymoses of suffocation. 3. The intensity of the hyperæmia, and the extent of the ecchymoses, are always in proportion to the efforts of the animal whilst struggling against submersion. It is the same also with the human subject, as has been verified in all necropsies made by the authors at the morgue in Paris during the last ten years. This fact permits one at a necropsy to learn concerning what passed in the last moments of life, to know whether or not the individual struggled long and vigorously during the act of drowning.—*British Med. Journal*, Oct. 4, 1879.

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Syphilitic Affection of the Placenta.—A very interesting observation of placental syphilis was presented at a recent meeting of the Académie de Médecine by M. Hervieux. A young girl of twenty-two years of age, five months pregnant, had contracted well-characterized syphilis. She, however, was confined at the full period of a well-shaped child in good health, but there existed in the placenta from fifteen to eighteen mammillated tumours, which Dr. Hervieux considered to be gummæ. His opinion was contested by Dr. de Paul and Dr. Larnier; but, whatever may be the true nature of the lesions, the case is one of a very interesting character.—*British Med. Journal*, Oct. 4, 1879.

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Influence of Medicinal Agents on the Fœtus.—Dr. Kurassow reported (*St. Petersb. Med. Woch.*, Sept. 20) to the St. Petersburg Medical Society the results of some experiments which he had performed. In three instances a drachm of chloroform, and in six from a scruple to half a drachm of chloral hydrate, was administered as an enema to a woman in labour, sometimes in a single dose, and at others in several times. They were as follows: 1. Both substances given in medium doses exert a decided effect on the fœtus. 2. Both appear to act in a similar manner. 3. At first a stimulant effect is produced, as shown in the more active movements of the child, and in the increase in force and rapidity of the action of the heart. Later this action becomes less forcible and slower, and the movements of the child are exerted less readily. 4. The effect is induced rapidly, viz., in five, or at latest ten minutes. 5. Chloral acts more rapidly and forcibly than chloroform, even when chloroform-narcosis is produced. 6. Chloroform can always be detected in the blood of the funis. 7. After injection of chloral a slight excitement is also produced in the mother, which is followed in two or three hours by a diminution of temperature.—*Med. Times and Gazette*, Oct. 11, 1879.

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Subconjunctival Entozoa.—Under this title, Dr. Fieuzal has published in the *Gazette Hebdomadaire*, September 12, a paper which he read at the recent congress at Montpellier, giving an account of two cases of subconjunctival hydatids that he has met with at the Clinic of the Hospice des Quinze-Vingts, of which he is senior physician. One of these occurred in the person of a girl sixteen years of age, the cyst containing the *tœnia echinococcus* having formed amidst the fibres of the rectus externus, producing a tumour as large as a chestnut. The other occurred in a girl three years of age, and consisted in a tumour the size of a nut, placed between the insertions of the rectus inferior and the rectus internus. On the extirpation of the tumour a vesicle the size of a cherry was removed intact, containing a *tænia solium.*—*Med. Times and Gazette*, Oct. 4, 1879.

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Changes in Volume of the Spleen.—The functions of the spleen are still so little known, that considerable interest attaches to all researches relating to the subject. A note lately addressed to the Académie des Sciences by M. PICARD describes some recent investigations which he has made on this point. The nerve-fibres, he says, which are distributed to the spleen are known in respect of several of their physiological properties. It is known that this organ receives motor nerves; since, when the splenic nerves are cut and irritated on the peripheral side, they produce contraction of the spleen. It is known also that it receives, in respect of nervous centres, irritation of the central ends of the same nerves producing pain. We know, moreover, at least partially, the course followed by the motor filaments, since the irritation of the peripheral ends of the splanchnic nerves produces the same effect as that of the peripheral ends of the splenic nerves themselves. But if these facts are well established, it is none the less true that they do not suffice to enable us to understand the changes in volume which are produced in the physiological state of the spleen; they do not indicate to us in any way the process which leads to the dilatation, and are equally incapable of explaining to us how the contraction is produced. "I have," says M. Picard, "very carefully endeavoured to elucidate these important points, and if I have failed to arrive at any result as to the nervous mechanism which determines their dilatation, I have at least succeeded in determining a contraction by reflex action, as the following experiment will show. In a dog in the act of digestion, the spleen was drawn outward from an opening in the left hypochondrium. A short time was allowed to elapse, until the phenomena of excitation by the air and cold had disappeared and the organ appeared in partial paralysis. This state was recognized by various characteristics. The surface becomes smooth, the colour more or less violet bluish, and the consistence soft. At this moment, the left pneumogastric nerve was laid bare and divided, and its central end irritated with an induced current. Under the influence of this centripetal action, phenomena were observed in respect to the spleen identical with those which the excitation of the peripheral ends of the splenic nerves would produce; the general volume of the organ was diminished by the loosening of its length, of its breadth, and of its thickness. Its colour became a pale red, its consistence became firmer, and its surface unequal and rough. In a word, by this action the contraction of the spleen had been determined. This result clearly ascertained, things were allowed to return to their former state, and then the right pneumogastric nerve was cut, and its central end was acted on by the induced current. This action produced exactly the same phenomena which had been observed while acting on the left nerve, and also determined in a similar manner contraction." From this experiment and the facts related above, it may be concluded that the contraction of the spleen in normal life results from a sensitive action which reaches centres following the trunks of the two pneumogastric nerves, whilst the centrifugal action which follows it passes along the spinal cord and the splanchnic nerves. If it be easily ascertained by experience how to excite contraction of the spleen, whether direct or reflex, it is, on the contrary, not possible to obtain the inverse effect—dilatation. M. Picard was unable to obtain this by nervous centripetal excitation. In the presence of these negative results, he is led to think that this state may well result simply from the modifications which the circulation of the vena portæ undergoes in normal life. When the circulation of the vena portæ is very active, that organ gradually dilates, as occurs when the course of the blood is disturbed even slightly in the splenic vein; in other words, the dilatation of the spleen would result from nervous dilating influences exercised by the digestive organs, whilst this contraction would result from a special well determined nervous action.—*British Med. Journal*, Aug. 16, 1879.

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An Almond-Shell in a Bronchus.—The following curious case is published in No. 54 of the *Allgemeine Med. Central-Zeitung*, 1879. A servant-girl, aged 19, swallowed one evening a piece of an almond-shell. She began to cough immediately after the accident. The cough lasted through the night, and was accompanied by vomiting, dyspnœa, and severe pain in the throat. The pain gradually extended over the right half of the thorax, and the patient expectorated a very offensive bloody sputum. When she presented herself at the hospital three weeks later, slight dulness was found on the right side of her back, extending from the middle of the scapula downwards; the breath-sound was feeble and vesicular on the back; sonorous rhonchi were heard in front on the right side and in the right interscapular space. She complained of pain in front of the upper part of the thorax when coughing. There was no fever. Five days later, pleuropneumonia of the right side broke out, which was only definitely cured after two months and a half, when the patient left the hospital feeling well, with the exception of the above-mentioned sensation of pain when coughing. The sonorous rhonchi could still be heard. Three weeks later, she again felt very unwell, and re-entered the hospital. A few days afterwards, during a violent fit of coughing she coughed up a piece of rough almond-shell with ragged borders. It measured nearly nine-tenths of an inch in length, more than a sixteenth of an inch in breadth, and was one-third of an inch thick. The patient recovered rapidly. It is remarkable that a foreign body of such a size could be aspirated into the bronchi, and that not more injury was caused by its roughness and ragged edges. —*British Med. Journal*, Sept. 6, 1879.

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Influence of Singing upon Health.—The *St. Petersburg Weekly Med. Journ.* writes: Professor Manasseïn of this city has published the result of a most interesting inquiry in which he has been engaged. He has made an examination of two hundred and twenty-two singers, varying in age from nine to fifty-three years, with particular reference to their chest-measurement and pulmonary condition, as compared with persons who are not singers. He finds that the size of the chest is greater among singers than other classes, and that the relative advantage increases with the age of the vocalists. Among singers who drink, he is convinced the habit prevents the due development of the chest. The vital capacity of the lungs is also greater in vocalists than in other persons. Singers often suffer from soreness of the top of the throat, but seldom from bronchial catarrh; and the mortality from phthisis among them is, therefore, small. Vocalists, both drinkers and non-drinkers, are, however, more subject to Bright's disease than people who do not sing. Singing is an excellent prophylactic for incipient consumption; and, as a means for the development and strengthening of the chest, is more efficacious than gymnastic exercises.—*British Med. Journal*, Aug. 23, 1879.

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The Temperature of the Stomach.—For several years, Dr. WINTERNITZ, of Vienna, has held the opinion that the temperature of the stomach may be ascertained by means of a short maximum-thermometer introduced through a tube. The idea has been carried out, under his direction, by Herr Griener, an optical instrument maker in Munich. He has made a maximum-thermometer six centimetres (about 2.4 inches) long, slightly curved in the lower third in order to pass easily over the root of the tongue and the larynx. The scale of the instrument extends from 35° to 42° Celsius (95° to 107·6° Fahr.), and is graduated in tenths of a degree. At its upper end is a small glass ring, through which is passed a strong thread, the ends of which are brought out through a stomach-tube. The upper end of the thermometer is also fastened to the tube by means of a solution of gutta percha. The tube, with the thermometer, is then introduced into the stomach in the same way as the stomach-pump. It has been found by experiment that the thermometer can be introduced into the stomach in from five to ten seconds, and that from fifteen to twenty seconds elapse before the mercury rises. The maximum temperature is reached in four or at most five minutes. If resistance to the passage of the tube be produced by the irritability of the larynx or œsophagus, the thermometer may be cooled by means of ice, which retards the rising of the mercury for a minute and a half or two minutes. Dr. Winternitz has also endeavoured to ascertain the effect of cold injections into the rectum on the temperature of the stomach; and has found that irrigation with 1000 cubic centimetres of water at 52° Fahr. (11° Cent.) for twenty minutes caused a fall of nine-tenths of a degree (Centigrade); the temperature of the stomach falling below that of the axilla. This confirms the already existing belief, that the body-temperature can be lowered by the injection of cold water into the rectum. Dr. Winternitz says that he has found cool enemata and rectal irrigations to exert a powerful influence on the temperature in cases of hyperæmic and inflammatory affections of the stomach, liver, spleen, and neighbouring organs.—*British Med. Journal*, Aug. 16, 1879.

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Myopia and the Colour of the Eyes.—M, NICATÉ stated (*Progrès Méd.*, Sept. 13) at the meeting of the French Society for the Advancement of Science that as one of the results of his examination of 3434 eyes in relation to myopia at Marseilles, this defect was observed far more frequently in light than in dark eyes, blue and gray furnishing 18 per cent., and black and brown eyes only 11.27 per cent.—*Med. Times and Gazette*, Oct. 4, 1879.

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A New Material for Filters.—A report has been made to the Secretary to the Admiralty by Major CREASE, Royal Marines, on the filters at present in use in the Royal Navy. Speaking of the carbon which is at present used as a filtering medium, Major Crease points out that it has one disadvantage—viz., instead of clearing out, it rather affords to the water passed through it, materials which assist in the development of some of the lower organisms. Spongy iron has not this disadvantage, but is slow in its action, and occupies much space in a filter. A newly devised carbonized mineral, which has been called carferal, and which combines carbon, iron, and silicate of alumina, has been experimented upon by analytical chemists, and the results of their examination are stated to be that it has all the advantages of spongy iron and carbon without any of their drawbacks. The use of carferal is therefore recommended for filters in the Royal Navy.—*Med. Times and Gazette*, Oct. 11, 1879.

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International Medical Congress, Amsterdam, 1879.—The sixth International Congress of Medical Science was held at Amsterdam, September 7th to 13th, under the Presidency of Professor Donders, of Utrecht. Doctor Guye was elected Secretary-General. Professors W. Tilanus, of Amsterdam, and Bouillaud, of Paris, were elected Honorary Presidents. And the following Vice-Presidents: Verneuil, for France; Lister, for England; Virchow, for Prussia; Schmitz, for Austria; Groscz, for Hungary; Crocq, for Belgium; Palasciano and Semmola, for Italy; Kock, for Luxembourg; Silva Amado, for Portugal; Sayre, for the United States; and Marcowich, for Roumania.

A number of valuable papers were read, abstracts of the more important of which will be hereafter laid before our readers.

The Congress closed with a banquet offered by the profession of Amsterdam to their foreign colleagues. The next meeting will be held in England.

One of the most remarkable features of the session was the popular ovation accorded to Mr. Lister when he arose to address the Congress on the antiseptic system. He was greeted with great enthusiasm by the largest audience that was assembled at any meeting of the Congress, was listened to with marked attention, and at the conclusion of the address he received the same enthusiastic applause with which his appearance was greeted.

Dr. Sayre, of New York, demonstrated before the surgical section his method of treating spinal curvature by suspension and the plaster-jacket, and was also the recipient of marked applause. At the reception by the civic authorities given at the Hotel de Ville he replied, in the name of the United States, to the welcome addressed to the Congress, and made a happy reference to the fact that New York was first called "New Amsterdam," and to the pleasure it afforded him as one of her sons "to express the imperishable debt of gratitude she owes to the Old Amsterdam which now welcomes representatives of America to this Congress."

Of the private entertainments the most notable were a dinner given by Prof. Sayre, of New York, to about fifty of the more distinguished members of the Congress, and a farewell banquet by the President, Prof. Donders.

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The Library of the Royal Medical and Chirurgical Society.—This library was started in 1805, and now comprises upwards of 31,000 volumes. The society has just published a catalogue of its collection in three large volumes—two devoted to an alphabetical list of authors, transactions, etc.; and the third to an index, catalogue of subjects—one main and novel feature of the latter being the grouping of the works on each subject in chronological sequence.

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Canada Medical Association.—The 12th annual meeting of the Canada Medical Association was held at London, Ont., on the 10th ult. Dr. John Donald, President, in the chair. A number of scientific papers were read. Dr. R P. Howard, of Montreal, was elected President for the ensuing year, and the Association adjourned to meet in Ottawa on the first Wednesday of September, 1880.

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Prof. Hebra.—The *Allg. Wiener Med. Zeitung*, announcing that this distinguished dermatologist has been made a Hofrath on account of the great services which he has rendered to science, observes that this is a well-deserved recognition of the deserts of one who is an ornament to the Vienna School of Medicine, to the celebrity of which he has so much contributed for more than thirty years.—*Med. Times and Gazette*, Oct. 4, 1879.

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Alexis St. Martin.—Alexis St. Martin, the well-known fur trapper, who had an artificial gastric fistula, and was the subject of Dr. Beaumont's valuable experiments on digestion, is said to be still alive, at the age of seventy-eight, and to be residing at St. Thomas, Joliette County, Province of Quebec, Canada. He is reported to be in straitened circumstances.

—

Obituary Record.—At sea, on the 20th of October, George William Callender, F.R.S., Surgeon to, and Lecturer on Surgery at St. Bartholomew's Hospital.

Mr. Callender's many friends on this side of the water will learn with sincere regret the sad termination of his holiday trip to this country. He arrived here accompanied by his two elder daughters, at the end of August, apparently in excellent health; a month later he began to experience fatigue in travelling, which was aggravated by the extreme heat of the season, to which he was unaccustomed. In the early part of October, while in Philadelphia, he suffered from malaise, dyspnœa, and other symptoms, the gravity of which led him to seek medical advice. Dr. Da Costa was called in, and found him labouring under unsuspected advanced Bright's disease, of a chronic form. Notwithstanding his extremely ill condition, it was deemed advisable, after careful consideration of his case, in consultation with Drs. Bartholow and Levis, to yield to his strongly expressed desire to return home. Accordingly, on the 15th of October, he was conveyed on a stretcher by a special train to Jersey City, and thence by a tug to the steamship Gallia. He bore this part of the journey so well as to encourage his friends in the hope of his reaching England and passing his last days at home, but a cable dispatch from Queenstown informs us of his death when five days out. While sick in Philadelphia he was the guest of friends from whom he received every attention that kindness and sympathy could suggest.

Mr. Callender was not only an accomplished surgeon and a careful operator, but a man of wide general culture. Although not a prolific writer, his contributions always commanded attention as the results of a large experience and of careful observation. He held the positions of Surgeon to the Charter House, and Examiner in Anatomy at the University of London. In 1877 he was elected President of the Clinical Society of London.

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HENRY C. LEA—Philadelphia.

THE MEDICAL NEWS AND LIBRARY.

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CLINICAL LECTURES.

ON THE METHODS USED IN THE TREATMENT OF FRACTURES AT THE PENNSYLVANIA HOSPITAL.

A Clinical Lecture delivered at the Pennsylvania Hospital, Nov. 8, 1879.

BY THOMAS G. MORTON, M.D.,
One of the Surgical Staff of the Hospital.

(Reported by Frank Woodbury, M.D.)

GENTLEMEN: My lecture this morning will be on the treatment of fractures of the long bones, with special reference to several methods which may be said to be peculiar to or which have originated in this institution. We have a right to express ourselves, I think, somewhat decidedly in regard to the treatment of fractures from the fact that a very large number of these injuries are annually received in this pre-eminently an accident hospital. Upon referring to the books, I find that since my connection with the hospital as surgeon we have had more than six thousand five hundred fractures under our care, and that during the past five years we have treated:—

COMPOUND FRACTURES—
36 of the cranium and face.
8 of the trunk and pelvis.
121 of the superior extremities.
213 of the inferior extremities.

SIMPLE FRACTURES—
85 of the cranium and face.
141 of the trunk and pelvis.
360 of the superior extremities.
711 of the inferior extremities.
19 cases of united fractures, and
31 crushes—the result of railroad injuries—make a total of 1725.

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This list does not include a very large number of fractures, more particularly of the smaller bones, which, after the first dressing, are turned over to the out-patient department. I refer to fractures involving the fingers and metacarpal bones, and not infrequently fractures of the forearm, and sometimes of the humerus, in the treatment of which admission to the wards was either not required or not desired by the patient.

In taking up the subject of the general treatment of fractures, we may now consider what is required upon the patient's admission. The fractured limb should never be roughly handled ; all manipulations must be made with gentleness. If the patient is irritable or in pain, we use an anæsthetic; by this means we can clear up any doubt in the diagnosis; for then we can examine the part without any embarrassment from the sufferings or struggles of the patient. Should the injury be in the neighbourhood of a joint an anæsthetic is of the utmost assistance and occasionally indispensable. In examining the injury avoid all haste, proceed with deliberation, systematically and carefully; rough handling may not only injure nerves and bloodvessels, but provoke cellular inflammation. Should the parts require cleansing, it should be done at once before the fracture is dressed, so that there shall be as little disturbance afterwards as possible.

In considering the general principles in the treatment of fractures, there is one point which I wish to thoroughly impress upon the class as a cardinal rule, viz., *simplicity of apparatus and frequent inspection.* Some years since some new splints were brought to the hospital for trial, and presented to the late Dr. Norris, who was then one of the attending surgeons. The chief recommendation for the apparatus was, that after the fracture was dressed, there was no need for the removal of the splint until the fracture was united, and Dr. Norris replied that this would be a grave objection to their use, as he made it a rule invariably to examine almost daily such cases in their progress towards a cure. Thus we object to the practice of "fixed dressings," so called in the early treatment of broken bones; later when the fracture is firm, the application of the silicate, starch, plaster of Paris, or binders' boards, comes in very well. The use of the latter is most frequent with us; the great advantage is, that binders' board can be cut, moulded in hot water, and neatly applied; after it has dried, a soft padding can be placed along the limb, and with a roller bandage as firm a dressing is obtained as is required; with this advantage, that it can be removed each day, the limb frictioned, all deformity removed, and every source of irritation prevented. It is not surprising that fractures should now and then be followed by no union, when from continuous tight fixed dressings the circulation is enfeebled. After the diagnosis of the fracture has been made, we then proceed to adjust the fragments, and bring them in apposition, and thus reduce the deformity. This is commonly called "setting the fracture," but even if it is possible at once to bring the broken ends of the bone in contact with each other, practically it is impossible to keep them so; thus the setting of a fracture is a process which requires often many days of careful manipulation and close attention. Take, for instance, an oblique fracture of the thigh; there will be more or less overlapping for some time in spite of our extension, so that we have to increase the extension, tire out the muscles, and mould the parts; this is only accomplished by daily "setting," or bringing the fracture in position. More or less swelling follows fracture as a result of the contusion of the adjacent soft parts; should the injury extend to the joint this is often very marked; therefore, we never apply a bandage upon a fracture until the œdema or swelling begins to subside; absorption has then carried off part of the exudation, and the firm pressure now of a well-applied bandage will aid the process. An immense amount of apparatus, often very complicated, has been devised for the treatment of fractures; much of it is perfectly worthless, and generally it is very costly.

After fractures have united, we use binders' boards, starch, silicate and occasionally the plaster-dressing, to keep the limb absolutely at rest, not as fixed dressings. After these dressings have dried, they are cut down the front and back; this gives us two lateral well moulded splints, which can easily be taken off and are retained in position by a single roller.

The starch bandage was introduced in Europe by Suetin in 1834, and since then has been in general use. In application, it is convenient, readily obtained and clean; we often use it in this hospital after the union is moderately firm. The starch is prepared as it is for starching linen, and as each turn of the roller is made, a mass is rubbed on; two or three thicknesses of bandage will thus make a very firm dressing. In compound fractures we make an opening in the dressing after it has dried, so that discharges can readily escape.

The silicate of soda, like the starch, makes an eligible dressing.

The plaster of Paris we seldom use in the hospital; it possesses no advantages over the starch, silicate, or binders' board. Should you wish to use it, thoroughly dust finely-powdered plaster on the muslin as it is rolled into a bandage, then dip the roller into water, and, when it is saturated, it is taken out and smoothly applied, and with each successive turn the soft plaster is rubbed into all the folds of the bandage.

I will now call your attention to some of the more important fractures of the long bones, and present to you the main points in treatment, commencing with the upper extremity.

Fractures of the clavicle are treated in any number of ways, and the multiplicity of methods and apparatus shows conclusively that there is no one recognized plan. Dr. "Fox's apparatus," which is known all over the world, was introduced into this hospital by that surgeon in 1828; it forms a very effective dressing, and at once fulfils the indications in the treatment of the fracture by keeping the shoulder and arm upwards, outwards, and backwards. The apparatus consists of a wedge-shaped axillary pad, which is placed under the head of the humerus of the affected side; on the opposite shoulder is arranged a ring or collar, to which the pad is fastened by strings across the chest, back and front. The arm is now placed on the front of the patient's chest, and the elbow well supported by a strong muslin sling. There is no apparatus better than this for general use, as it allows the patient to attend to business, and gives excellent results; nevertheless, in many cases some deformity results, from the fact that the patient in moving about produces some jarring of the limb, and the bone becomes overlapped. In treating a broken clavicle in the female it is often very important that not the slightest deformity shall result, and we are obliged to take unusual precautions; we guard against deformity by adopting the "postural treatment;" the patient is placed upon the back on a moderately firm mattress with the shoulders kept horizontal, the head resting on a very thin pillow; the hand and forearm rest upon the chest or abdomen. This supine position is maintained until union is firm. We treat most of our clavicle fractures by this method, and we have no deformity resulting This treatment was recommended by Hippocrates, and is as old as the hills.

Fractures of the sternum and scapula require only a brief mention, for we have nothing new to offer in connection with them; we mould the parts if much displaced, and then apply pads, a retaining bandage, with rest in bed, is all that will be needed as a rule.

Fractures of the ribs, unless complicated by wound of the lung or pleura readily recover with the simplest form of dressing. We partly encircle the chest with strips of adhesive plaster, two and a half inches wide; these strips are made to slightly overlap one another until a space of six or eight inches is covered; the patient is compelled to breathe with the diaphragm, which relieves the pain, by having the ribs at rest. All *fractures of the humerus* above the condyles, including the head and neck of the bone, are treated either with the anterior or internal angular splint; if with the latter, we use a moulded humeral binders' board splint; more commonly we bring the humerus to the side, close to the ribs, which act as the internal splint; a bandage is first applied from the hand to the shoulder, then the arm is bound to the chest, and a moulded shoulder cap of binders' board covers the acromion and humerus. In warm weather a light towel is placed in the axilla to absorb the perspiration and prevent irritation and excoriation. In fractures of the condyles we use either the anterior or internal angular splints. In order to avoid anchylosis we vary the splints and the angles almost every day, thus keeping up a certain change of position, and, as soon as repair begins to take place, we use passive motion daily.

In *fractures of one or both bones of the forearm* we use two straight splints: the one should go from the bend of the elbow to the finger ends, the other upon the opposite aspect of the arm, from the elbow to the wrist only; be careful that the epicondyle of the humerus is not pressed upon by the splint. In applying these splints we aim to preserve the motions of pronation and supination. In applying splints to the forearm we should have the thumb upward, so that the patient can look into the palm of his hand; in this position the radius and ulna are most widely separated.

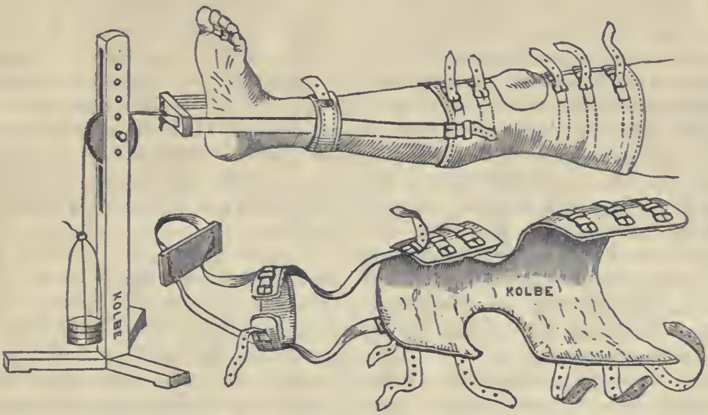
Fracture of the olecranon process is treated by extreme extension, the arm and forearm being placed on a straight splint.

We recognize especially two *fractures at the lower end of the radius*; the one, "Colles's fracture," which is an inch or an inch and a half above the wrist, and "Barton's fracture," which extends obliquely from the articulation, backwards and upwards; thus separating more or less of the posterior articulating surface. The latter fracture has also been called the "silver fork" fracture, because the wrist has a peculiar curve which was thought to resemble a silver fork, produced by the fracture with deformity of the wrist. We use more commonly the old splint devised by the late Dr. Henry Bond, of this city, with excellent results, not only in the Barton, but in the Colles fractures. Within a short time Dr. Levis has introduced a splint which allows the hand to drop to a slight angle, the radius is thus thrown upwards. If, as is often the case, there is great deformity with the fracture, it must be reduced at once, using ether, if the parts do not yield to manipulation; after the reduction, small square pads, placed above and below the wrist with the bandage, will always keep the fracture in good position. The great advantage of the Bond splint consists in the unrestricted motion which is allowed the fingers, thus avoiding the partial consolidation of the tendons at the seat of fracture. Dr. Levis's splints are rights and lefts; they are of galvanized copper, moulded to fit the forearm, and, as already stated, they allow the hand to drop forward.

Fractures of the fingers are generally compound, and often comminuted, with more or less laceration of the soft parts; any portion of a finger saved is of immense value especially to the artisan. I would, therefore, urge upon you *never* to make a primary amputation of a finger be it ever so seriously injured, but wait until nature gives the indication for a secondary operation. You will thus save many a finger, which at the time of the injury seems hopeless, or, if required to be secondarily amputated, less loss of tissue will generally be required.

Fractures of the vertebral column and pelvis are simply kept at rest as far as possible, and the ordinary means employed to reduce deformity. The catheter is generally needed, and great attention to prevent bed-sores.

We now come to the treatment of *fracture of the femur.* The practice of making extension by lateral adhesive strips originated in this House. The apparatus is easily made and quickly applied. It is simply a 2½ or 3 inch adhesive strap, long enough to reach from just above the knee to the sole of the foot and up the other side to the same level, always taking care that the strips do not overlap the broken extremity. In the middle of this strap a piece of wood (2½ × 4 inches) is placed, which serves to keep the lateral straps from pressing on the malleoli, and to it the weights for extension are attached. Strips of plaster are also made to gird the limb above and below the knee, and above the ankle in order to prevent the apparatus from slipping. A roller bandage is applied outside of the dressing from the foot to the hip, and sand-bags are placed one on each side of the limb to support it in good position. The lateral strips must not be allowed to go above the point of fracture, or the extension will be rendered useless; if they are applied tightly during swelling, when it subsides there will be wrinkles and folds that may cause ulceration. This dressing may slip during warm weather, and require re-application; and in the case of a male adult, the leg must be shaved before the plaster is applied, or pain will be produced in removing it. These are trifling objections, however, and do not impair the usefulness of this simple method of treating fracture of the femur, which is constantly employed in our wards. The method of making extension deserves a word of description. You see here a wire crib, whose base is of the same size as the weights employed. Into this we drop as many pound weights as we wish; and in this way can regulate precisely, from day to day, the amount of extension; it is more easily managed than when extension is made by a brick or bag of salt, or sand.



I now show you another apparatus for making extension in the treatment of fractured thigh. Most of us are a little partial to our own devices, and perhaps I like this the more because it is original. It is the same in principle as the preceding, and is made as follows: the circumference of the thigh and leg is taken, that of the former four or five inches above the knee, and the latter four inches below the joint; leather, buckskin or any stout material may be used, which is cut according to the measurements to encircle the limb between these two points; an opening is left for the patella; the portions of the apparatus above and below the knee should buckle or lace up above separately; on the outside of this a band of any stout material is buckled or sewed, it should be long enough to extend to the sole of the foot and up on the inner side of the limb to the knee, where it is fastened in like manner; just above the ankle a band encircles the limb, which keeps the extension strips in position. As the band passes around the sole it is attached to a piece of wood, the same as is used in the adhesive plaster extension, and sand bags complete the dressing. This apparatus is easily applied, and can be removed as often as desired, to wash or rub the limb; it does not interfere with circulation, and is very comfortable to the patient. This apparatus can be readily made by any one in a short time, or may be obtained from an instrument-maker by sending the girth of the limb above and below the knee, and its length; the apparatus can be used on either limb.

One point must not be forgotten. After applying the apparatus and the extending weight, the foot of the bed should be elevated about four inches. Since the body will incline to the lowest point of the bed, this will give us a counter-extension. Unless the bed is elevated, the foot will soon be brought in contact with the pulley, and thus take off all the extension from the limb. The muscles, shortly after a fracture, become irritated, and spasmodically contracted, thus producing pain, and disturbing the fragments; but, in the course of a few days, by the lateral pressure of the sand bags and the steady extension this condition of the muscles is overcome, and the fractured ends of the bone can be placed in perfect apposition.

In regard to *fracture of the patella*, a great many methods, too numerous to mention, have been recommended; but just as in fracture of the clavicle, I will confine my remarks to those in use here. What we desire in fracture of the patella is to keep the fragments in close apposition, and this, if possible, without cutting off the supply of blood to the bone, and in this way not interfering with repair. Much of the apparatus used has the serious fault of pressing upon the bone, and allowing little or no nourishment to reach it; an ununited fracture is, therefore, a frequent result.

Here is Dr. Agnew's apparatus. It is a straight posterior splint, having cross-pieces above and below the knee, to which the bandage is attached. The roller is then applied from one side to the other, going first above the patella and next below it, in such a way as to bring the bone into good position.

Of all the apparatus devised for the purpose, however, I maintain that the original Malgaigne's hooks answer the purpose most perfectly. I show you here a modification of these hooks, which Dr. Levis made a few years ago by separating the set into two pairs, which act independently. Another arrangement for the same purpose, that I frequently use, is a set of four movable hooks, two for the upper fragment and two for the lower, which like the preceding are brought together by a long screw. Either of these can be applied in any position we desire, and give excellent results; it may be called the Pennsylvania Hospital modification of treating fractured patella. The first case in which I used the Malgaigne's hooks was that of Bridget S., who recovered with perfect osseous union; she came in the hospital with a recent transverse fracture of the patella, an interval of two inches existing between the fragments. After treatment, I presented her for examination before a number of surgeons, who were unable to detect which patella had been injured except by the little scars left by the hooks. Extension and flexion were perfect. When there is a comminuted or stellate fracture of the patella, union is often remarkably good, because the greater injury leads to more irritation and more callus is deposited. In a simple fracture of this bone, there often appears insufficient irritation to produce the desired bony union, and hence the hooks act very beneficially. The hooks should not be applied until all inflammation has subsided; this we usually find between the fifth and seventh day; with an anæsthetic pain is avoided.

Fractures of both bones of the leg often require more care than fractures of the femur, whose treatment, as you have seen, is comparatively easy. To allow the greatest freedom to the patient, and sitting up in the bed, we often make use of the anterior splint, which is also employed by some surgeons in the treatment of fracture of the thigh. But the treatment of fracture of the leg for which this institution is best known is that by means of the fracture-box, made the length of the leg, with a permanent foot-piece and falling sides. When a patient with a recent fracture is admitted into the ward, his leg is enveloped in an evaporating anodyne lotion (generally lead-water and laudanum), and a small pillow is then placed in this fracture-box, upon which the limb rests. The foot is secured to the foot-piece, and two pieces of bandage are tied around the box to secure the sides from falling. This allows frequent inspection, and the change of dressings as often as desired, and when union has occurred we use lateral splints of binders' board. In compound fractures the box is sometimes filled with bran, it may then be swung, if more comfortable to the patient, in the same manner as by the anterior splint.

This fracture-box has given excellent results, and has been in constant use for many years. It is applicable to all fractures of the leg and foot except one; this peculiar fracture is when both malleoli have been broken, with the tibia dislocated backwards, the posterior part of the tibia comes in contact with the tendo Achillis, in fact the backward tibio-tarsal luxation of Malgaigne; if the fracture-box is used the heel is apt to be pressed up, and the deformity is likely to recur; there is now in the wards an example of this form of fracture, which is treated by suspension.

For *fractures of the lower end of the fibula*, Dupuytren's splint, or either the starch, silicate, or pasteboard dressings may be judiciously used, cut into lateral splints as before described, and the patient is at once allowed to be up on crutches. *Fractures of the tarsus and metatarsus* need not detain us, for we merely adopt the ordinary methods in common use by all surgeons.

HOSPITAL NOTES AND GLEANINGS.

Mr. Lister on Antiseptic Dressings.—After examining several cases at King's College Hospital, Mr. **Lister** made some remarks on the subject of the various dressings he used. He had found that carbolic acid very quickly went through gutta-percha tissue, less quickly through oil-silk, and less quickly still through oil-silk when covered with gum-copal. Therefore the "protective" he used for wounds was oil-silk prepared with gum-copal. That the dressing he placed above this was truly antiseptic he thought he could say was proved. When the dressings had been handed round it could be seen that after having been next wounds for three and four days there were no signs of putrefaction. If ordinary dressings had been used they would have been black and stinking under the same circumstances. There was a time when people did not believe in the existence of oxygen; and there were people who did not believe in the existence of septic germs; but he believed that their presence had been demonstrated, and that the germ theory was more and more becoming accepted. Carbolic acid had been found to be most effective in preventing septic action. It might be used in various ways. If added to water a comparatively weak solution could be made, but the carbolic acid was very easily given up, and, if tested by touching the tongue with it, a one-in-twenty solution would be found to be almost caustic. Again, if added to oil, it formed a comparatively bland and stable solution of one in eight, and if mixed with resin it combined in the proportion of one in five to form a still more stable compound. When he first found that carbolic acid united with resin, and noticed its apparent change of properties, he thought that there must be some chemical change in the acid; but experiment showed that it was only given off more slowly, while it retained all its properties. This is the form now in which he uses the acid as a dressing, impregnating ordinary gauze with it. In addition, four parts of paraffin are added to the mixture to prevent the gauze becoming too glutinous. The advantage of this preparation is that it does not irritate the skin by too strong action, but that it keeps giving off the carbolic acid slowly, and lasts for a long time. He always wets the first layer in a watery solution of carbolic acid in order to have the wound and drainage-tube quickly brought under the influence of the antiseptic. Usually about eight layers of gauze are necessary for ordinary dressings. The use of the outer layer of mackintosh is to prevent the discharges soaking directly outwards; it directs it over the whole surface of the gauze, and thus makes a great many layers unnecessary.

A man was then brought into the theatre with a large ulcer of the leg, which had been dressed the previous week with benzoic acid. This, Mr. Lister said, was an antiseptic dressing new to them at King's College. On examining the leg (which had been dressed three days previously) it was found that all the dressings were sweet, that the ulcer was presenting healthy granulations, and that its surface was raised to a level with its edges. When last examined it had been unhealthy and excavated. Benzoic acid had proved here to be truly antiseptic. The ulcer was dressed by washing it carefully with a watery solution of benzoic acid, covering it with protective and lint saturated with benzoic acid, and bandaging in the usual way. Mr. Lister had heard of men using the spray for dressing such wounds, but the spray was only meant to be used to prevent septic matter entering a cavity, and was not at all necessary when dressing superficial wounds.—*Med. Times and Gaz.*, Nov. 1, 1879.

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Wound of Right Internal Jugular Vein with a Fragment of Glass from an Exploded Lemonade Bottle; Copious Hemorrhage; Ligature; Persistent Contraction of Right Pupil; Remarks.— Thomas P——, aged fourteen, was admitted to the Worcester Infirmary, under the care of Mr. THOMAS WALSH, on July 29th, 1878. He was employed in a soda-water manufactory, and while in the act of stooping to pick up some bottles, a man in passing dropped a bottle of lemonade, which burst, and one of the fragments struck the boy on the right side of the neck, causing a wound about two inches in length, beginning about an inch above the clavicle, close to the trachea, and passing obliquely upwards and outwards across the anterior edge of the sterno-mastoid muscle. The man picked the boy up, and, with great presence of mind, pressed firmly on the wound, holding as well as he could the edges together, and ran down to the infirmary with him.

When first seen the boy was not at all collapsed, though he had lost a considerable quantity of blood. Directly pressure was removed by the man withdrawing his hand, the blood, venous in character, gushed out in a large and continuous stream, though, not being able to see any bleeding-point, the house-surgeon *pro tempore*, Mr. Wilson, endeavoured with a pair of artery torsion forceps to catch hold of the divided ends of the vein (for it was clear the bleeding proceeded from the internal jugular vein), but after trying some time without success, and the boy getting faint from the excessive loss of blood, he seized hold of the edges of the wound and held them firmly together, thus effectually controlling the hemorrhage, and sent for Mr. Walsh. On the arrival of this gentleman the boy had somewhat rallied. The clot which had formed was removed, and the blood welled up most alarmingly. An attempt was made to control the bleeding by pressure above and below in order that search might be made for the bleeding ends, but the wound in the vein was so near the innominate that no pressure below controlled the bleeding in the slightest degree. The boy was then placed under chloroform, the wound enlarged, and then, after several ineffectual efforts to seize the bleeding ends, Mr Walsh pressed with his left forefinger behind the posterior edge of the sterno-mastoid muscle, and thus, as it were, exerted pressure from behind, and in some measure moderated the bleeding, which chiefly came from the lower or cardiac cut-end of the vein. He then fortunately seized both ends, and included them in one ligature. It was not, however, quite clear what had been included in the ligature, whether the descendens noni nerve, or even the par vagum, the chief aim being to save the boy from immediate death by bleeding, and any attempt at dissection was out of the question. The hemorrhage now ceased, and the wound was united by sutures and dressed in the usual way. He was put to bed with hot bottles to his feet, and in a short time he drank a little milk. At 11.30 P. M. the nurse thought he was dying, and called Mr. Walsh, who found him fast asleep, his respiration being only four per minute. He was awoke, when he said he was very comfortable, his respiration while awake being normal. In a few minutes he fell asleep again, when his respiration once more dropped to about four per minute, and was rather stertorous in character. In about an hour's time his respiration became normal.

On July 30th he was very drowsy all day, sleeping continually, though easily roused; temperature 101.8°. Next day he seemed much better.

On August 1st the temperature went up

to 102.1°, the pulse being 114 and the respiration 24. On the 2d the drowsiness had nearly passed off; the ligature came away, the wound looking sloughy; temperature 99.2°. Four days later (the 6th) the wound had almost healed, and for the first time the right pupil was noticed to be contracted and the left dilated. On the 11th the pupils became very nearly equal. On the 14th the pupil of the right eye again contracted; the wound was healed; he complained of pain in the left knee-joint, which was found to be swollen and inflamed; temperature 101°; a back-splint was applied. On the 17th the knee was perfectly well; temperature normal. On the 21st he was discharged quite well, but with the right pupil still contracted and insensible to light.

On October 23d he came to show himself. Said he was quite well, though he looked rather heavy and dull. The right pupil was still contracted and insensible to light, while the upper eyelid drooped a little. The vision of both eyes was perfect.

Remarks by Mr. Walsh.—I have thought this case worthy of publication—first, because of the extreme danger attending wounds of the internal jugular vein, for even if hemorrhage be arrested (and many cases are on record where the attempt has failed), unhealthy inflammation with all its dangers frequently supervenes. Mr. Bryant says "wounds of the internal jugular vein are probably more fatal than wounds of the carotid, and when near the cardiac end, in addition to the danger of hemorrhage, is added that of introduction of air into the heart." There is also secondary hemorrhage and pyæmia looming in the future as a probable complication. Secondly, I do not remember to have experienced so much difficulty before in seizing the bleeding vessel, the depth of the wound being considerable, and the space before enlargement contracted. Thirdly, the after-symptoms were rather inexplicable. Why should his right pupil be contracted and remain so? His head symptoms, as denoted by his extreme drowsiness, his infrequent respiration, etc., might be accounted for by his exhaustion from the loss of blood. Then, again, his threatened attack of pyæmia of the knee, which passed off in a day or two. Could a filament of the sympathetic nerve have been included in the ligature, and, if so, would that account for the above symptoms? Of course, it is clear that neither the descendens noni nor the par vagum was injured, or more serious results would have followed.—*Lancet*, November 1, 1879.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Pilocarpine in Intermittent Fever.—Dr. Gaspard Griswold, House Physician to Bellevue Hospital, from a study of seven cases of intermittent fever treated by muriate of pilocarpine in one-fifth of a grain doses administered hypodermically, concludes:—

1st. That the muriate of pilocarpine, administered hypodermically, will promptly cut short the chill of malarial intermittent fever.

2d. That in a large proportion of cases so treated the paroxysm aborts, terminating in the sweat caused by the pilocarpine, there being no hot stage.

3d. That such abortion of a paroxysm is in itself sufficient to effect a cure in many cases.

4th. That such abortion of a paroxysm is a valuable adjuvant to treatment with quinine during the intervals.

5th. That a dose of pilocarpine sufficient to produce this effect acts gently, without causing exhausting diaphoresis or unpleasant ptyalism.

The promptness with which an adequate dose of pilocarpine interrupts a chill is suggestive of its possible efficacy in cases of pernicious intermittent fever, where prevention of the full development of a paroxysm is often of the first importance.—*Med. Record*, Aug. 16, 1879.

Virginia State Medical Society.—The annual meeting of this Society was convened at Alexandria, on October 21, Dr. L. S. Joynes, of Richmond, President, in the chair. The following officers were elected for the ensuing year: President, Henry Latham, M.D., of Lynchburg. Vice-Presidents, Drs. W. H. Bramlett, of Pulaski;

R. C. Powell, of Alexandria; G. K. Robinson, of Danville; W. P. McGuire, of Winchester; W. H. Daughtry, of Southampton, and C. C. Conway, of Culpepper. Secretary, Dr. Landon B. Edwards, of Richmond. The next meeting will be held at Danville.

Jefferson Medical College.—The faculty have appointed Dr. Henry C. Chapman Demonstrator of Physiology in this school, and Professor of Physiology in the Pennsylvania Dental College, to complete the course of physiology left unfinished by the late Prof. J. Aitken Meigs.

Change in the Curriculum of the Detroit Medical College.—We take pleasure in announcing that the Detroit Medical College has recorded itself in favour of the improved curriculum, and has made the necessary changes, viz., preliminary examination, and a three years' graded course, to take effect at and after the session of 1880–81.

New Medical Journal.—We have received the prospectus of a new quarterly, to be called "The Chemist and Neurologist," and to be under the editorial control of Dr. C. H. Hughes, of St. Louis. The scope of the Journal is defined by its title, and its editor has long been known as an earnest student of his specialty.

The Physician's Visiting List for 1880.—Messrs. Lindsay & Blakiston have issued their Visiting List for 1880. In addition to the usual matter it contains an explanation of the metric system and a very full posological table. The whole forms a most convenient pocket visiting list, and is worthy of the good opinion in which it has been held by the profession during the twenty-nine years of its publication.

OBITUARY RECORD.—In this city, on the 9th of November, aged 50 years, JAMES AITKEN MEIGS, M.D., Professor of the Institutes of Medicine and Medical Jurisprudence in the Jefferson Medical College, Philadelphia.

Dr. Meigs was born in Philadelphia, on the 31st day of July, 1829, received his scholastic education in the public schools, and graduated in Medicine at the Jefferson Medical College in 1851. In 1859 he was appointed physician to the Philadelphia Hospital; in 1868 he was elected to the chair of Institutes in the Jefferson College, as the successor of the late Professor Robley Dunglison, and in the same year he was elected physician to the Pennsylvania Hospital. Dr. Meigs was deeply interested in natural history, and before his professional labours became all-engrossing, he was an active member of the Academy of Natural Sciences of Philadelphia. In 1857 he arranged, classified, and catalogued the extensive collection of human crania in the Academy; he was also the author of several important contributions to craniology.

Dr. Meigs was a successful practitioner, an earnest student, and an acceptable lecturer, and he endeared himself to his patients and his pupils by his many excellent qualities of heart and mind.

At a meeting of the Faculty of Jefferson Medical College, held November 10th, the following resolutions were adopted:—

Resolved, That the Faculty of Jefferson Medical College have learned with profound sorrow of the death of their friend and colleague, James Aitken Meigs, which occurred on the morning of the 9th instant.

The Faculty desire to express their keen sense of the great loss they have sustained. While bowing to the decrees of an all-wise Providence, they deeply mourn the removal, in the prime of life, of their beloved friend and associate.

Gifted with superior powers of mind, cultivated and matured by a life of study and research, and genial and kindly in his bearing, he won the admiration and confidence of all with whom he associated.

His clear and impressive manner in the lecture-room secured the attention and sympathy of his pupils, and rendered him eminently successful as the expounder of an extensive and difficult branch of medical science.

At all times cordially in sympathy with his colleagues and loyal to the interests of the school at large, the Faculty feel, that while they have lost a judicious and helpful companion, the Jefferson Medical College, for whose success he laboured so faithfully, has been deprived of both an ornament and pillar of strength.

Resolved. That, realizing the unutterable sadness thus brought upon the venerable father of Dr. Meigs, the Faculty desire to convey to him their sincerest sympathy and condolence.

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The late Mr. Callender.—The following minute was read by Prof. S. D. Gross at the meeting of the Philadelphia Academy of Surgery, held November 3d, and ordered to be spread upon the records of the Academy:—

"Since the last meeting of the Academy the melancholy news has been brought to us of the death of our friend, Mr. George W. Callender, of London, who, during his two late visits to Philadelphia—the last one only a few weeks ago—endeared himself to us by his many social qualities, his amiable and agreeable manners, his lofty character, his great professional intelligence, and his scientific attainments. It is sad to think that such a man, in the prime of life and in the full fruition of his renown as a representative surgeon of Great Britain, should be lost so soon to his family, his friends, and his profession. The circumstances under which he died were peculiarly distressing. It was hoped when he left us, on the 15th of October, that, ill as he was, he would be spared, at least, long enough to reach his home, to breathe out his life in the bosom of his family and in the presence of his friends, who loved and respected him so much for his many virtues. He died at mid-ocean in less than six days after he left our shores, in the presence of his two loving and loved daughters, the companions of his travels, to whom and to his other children we herewith tender our warmest sympathy, trusting that a good and merciful God, the Father of us all, may solace and comfort them in their deep affliction, occasioned by the loss of a parent so kind and good, of a surgeon so learned and accomplished, and of a citizen so pure and patriotic. Although Mr. Callender was not a member of our young Academy, all of us are familiar with his life and works, and it, therefore, affords us a melancholy satisfaction to pay this tribute to his memory and to his worth."

FOREIGN INTELLIGENCE.

The Medical Uses of Milk.—M. Biot, in the *Revue Mensuelle de Médecine et de Chirurgie*, March, April, and May, 1879, gives a summary of the clinical facts scientifically observed at the Hôtel Dieu at Lyons on this subject. The deductions and conclusions drawn by M. Biot touching the nature of acute articular rheumatism and the efficacy of the milk-regimen in the course of this affection, are based on a number of analyses of urine made as completely as possible, since they give the amount of the total nitrogen, of the urates, of the total chlorides, and of the phosphoric and sulphuric acids. His theoretical and therapeutical views on the subject are thus summarized. The fever of acute rheumatism generally lasts two or three weeks, and consequently, either from the time it lasts or on account of the rise in temperature, causes an enormous consumption of blood-corpuscles, which produces profound anæmia in the patient. The fall of temperature is the best criterion of the cure, and coincides exactly and constantly with the disappearance of the pains. The tortures endured by patients suffering from articular rheumatism are in themselves alone of a violence and tenacity sufficient to induce the physician to endeavour to oppose to this disease a treatment which would unite the three qualities *citò, tutò, et jucundè*. The milk-diet seems capable of fulfilling this desideratum; it causes the temperature to fall rapidly below hyperpyrexia, and simultaneously assuages the pains in a period varying from three to eight days. The effects from these two points of view are more prompt and more powerful if the patient be submitted to the milk-regimen at the outset of the affection. This milk-regimen, without overcharging the stomach or raising the temperature, by its nutritive power and its facility of digestion, prevents in great measure that characteristic and generally troublesome anæmia left behind by attacks of rheumatism. Besides these general effects, milk-diet has a special action on the urinary function, which is clearly indicated in rheumatism. Milk strongly favours the elimination of all the waste principles accumulated in the organism ; its exclusive use causes both the quantity of urine excreted in twenty-four hours and the quantity of all the saline principles dissolved in this liquid to increase rapidly ; density, on the contrary, experiences a proportionate decrease. The impetus given to the urinary function by a milk regimen allows a glimpse of the nature of rheumatism, its near and intimate causes. The analysis of urine seems to show that there is an accumulation of urates or uric acid in the organism of rheumatic sufferers, and that its diminution under the influence of milk is not one of the smallest benefits of this regimen.—*British Med. Journal*, Nov. 8, 1879.

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Balsam of Peru in Pruritus.—In a communication to the *Deutsche Med. Woch*, No. 34, Dr. Auerbach, of Berlin, states that having, in common with so many other practitioners, found the balsam of Peru a most valuable remedy in itch, he has for some time past treated pruritus by the same substance, and with the greatest success. After the first rubbing in to the part affected great relief is obtained, and in a few days a cure results. He relates a very obstinate case, which, after resisting all kinds of treatment for years, was speedily cured by the balsam.—*Med. Times and Gaz.*, Nov. 8, 1879.

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Monstrosity.—A remarkable case of monstrosity is reported in the *Wiener Medicin. Presse*, 1879, No. 9. The child had been born dead. The upper part of its body was single, the lower double. It had two faces on a skull, which was about thirteen centimetres wide. Both individuals were not equally well developed, the one being five centimetres shorter than the other (thirty five and thirty centimetres), and the external genital organs were absent. It had also a large bifid spine. There were four frontal and as many parietal bones, and two occipital bones. The spines were separate. Both breast-bones were united in one; at their lower end, there was an opening in the skin of the size of a palm, through which the intestines protruded. The corresponding parts of the cerebra were united; the cerebella were separate. The organs of the throat and thorax were double ; the œsophagus was single ; the stomach also; the intestines were double, but abnormally formed. A small intestine ran from the stomach into the pelvis of the smaller fœtus, where it developed into a cæcum furnished with a processus vermiformis which opened into a duct, from which the ileum of the normally developed fœtus sprang. This ileum ended in an anus in the larger individual.—*British Med. Journal*, Oct. 18, 1879.

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Carbolic Acid Poisoning.—The following curious case of poisoning by the application of carbolic acid to the skin is reported in the *Berliner Klinische Wochenschrift* for October 6th by Dr. HAUNHORST. During his residence as house-surgeon at the Lunatic Asylum of Ueckermünde, he was asked one night to see one of the nurses, who had not felt very well for several days. She was suffering from a commencing phlegmon on the right forearm. The limb was much swollen, red, and very tender to pressure. He applied pads of cotton-wool that had been soaked in carbolic acid to the arm, wrapped it up, and told the patient to go to bed. On returning to his room, Herr Haunhorst felt his fingers becoming numb, and began to suspect that the carbolic acid had been too strong. A few minutes later, he was summoned in haste to his patient. She had lost consciousness; threw herself about in bed ; her face was flushed ; the pupils were contracted; the pulse slow ; she breathed with much difficulty. The dressing was immediately removed, and a fresh one applied, which had been soaked in a 3 per cent. solution of carbolic acid. In the course of an hour, the patient recovered consciousness, and told him that immediately after the dressing had been applied she had felt a violent pain in her arm, and lost consciousness. She complained of fatigue and frontal headache. No urine could be obtained. The corrosive effect of the acid showed itself on the arm in several circumscribed white spots, beneath which the skin was exposed. The arm was healed in a fortnight, and the phlegmon had not broken out. The mischief had been caused by a mistake of the druggist, who had dispensed a 15 per cent. solution, instead of a 3 per cent. one.—*British Med. Journal*, Oct. 18, 1879.

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Death from Tetanus induced by a Hypodermic Injection.—An inquest was lately held by the coroner for the city of Dublin, on the body of a governess, aged about fifty-six years, whose death was attributed to the above cause. From the medical evidence adduced, it would appear that the deceased for years used to inject morphia herself subcutaneously, for the relief of neuralgia arising from bad teeth; and that the habit grew so upon her, that when suffering from this neuralgia her usual habit was to use twenty grains of morphia in the twenty-four hours. On the morning of the 10th ult., she had used twelve grains of morphia in one injection. Symptoms of tetanus showed themselves on the 12th, and were fully developed on the 14th. Dr. Austin Meldon, Surgeon to Jervis Street Hospital, who was called to see the patient, had her removed from her lodgings for convenience of treatment to his hospital. He was of opinion that the cause of the tetanus must have been the injury of some nerve by the needle in the self-administration of the injection on the 10th. From the 13th to the 17th, she was unable to swallow; but she recovered that power two days before her death on the 20th ult. Dr. Meldon deposed that the front of the body of the deceased was covered with innumerable scars from the punctures caused by the hypodermic needles; in fact, it was just as if she had been tattooed. He also stated that there was no case on record of such a large quantity of morphia ever having been used at a time as this lady had used. Two or three years ago, a case, he said, of death from tetanus produced by a wound from a subcutaneous injection occurred in London; but in that case, the dose was only two or three grains. He also knew of two other cases of lock-jaw produced in the same way. The jury found that the deceased died in consequence of traumatic tetanus supervening on a wound caused by the needle of a subcutaneous injection machine which deceased was in the habit of using, and that her death was the result of misadventure. This case is of much interest as bearing on the recognized possibility, as stated by Dr. Meldon, of the wound caused by a hypodermic injection inducing tetanus. We do not know of the particular case occurring in London alluded to by Dr. Meldon, or of the other cases he mentioned; but in the *Lancet* of July 6, 1867, three cases are referred to of death from traumatic tetanus after the hypodermic injections of sulphate of quinine; and in the same journal (December 16, 1876, p. 873), the case is reported of a lady who died at Southsea of well-marked tetanus after the use on herself of hypodermic injection of morphia, given, as it was supposed, with a rusty needle. With reference to this particular case, attention is directed to the symptoms resembling those of tetanus sometimes caused by morphia itself. In Dr. Meldon's case, however, this effect of morphia could not apparently have been in force, as he continued the injection of one grain of morphia when the patient was attacked with the tetanic spasms with instant relief to them.—*British Med. Journal*, Nov. 1, 1879.

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Nitrite of Amyl in the Night-Sweating of Phthisis.—Dr. William Murrell has recently made, at Dr. Ringer's suggestion, some observations on the influence of nitrite of amyl on the night-sweating of phthisis. The patients were seventeen in number, all adults—thirteen men and four women. All stages of the disease were represented; in some cases there was considerable elevation of temperature, whilst in others the lung mischief was latent. The majority of the patients were seen daily for some weeks, and some were under observation for three months. The medicine was given internally at bedtime, the dose varying from a half to three minims. For convenience of dispensing a one in ten solution in rectified spirit was usually employed, but in some cases the amyl was given in suspension in water or on sugar.

In three out of the seventeen cases no benefit was experienced from the treatment. These patients were all men. One had suffered from profuse perspiration all his life, not only at night, but also in the day-time, and he was covered with moisture on the slightest exertion even in the dead of winter. The amyl was given nightly in minim doses for a fortnight without checking the perspiration in the slightest degree. He had previously been treated unsuccessfully with oxide of zinc, hypodermic injections of atropia, and other drugs. On one occasion he was freely rubbed all over with belladonna liniment till his pupils were fully dilated, but the sweating continued as before. The second was a case of advanced phthisis, in which the amyl was given nightly for a fortnight in doses varying from one to three minims without benefit; oxide of zinc subsequently failed. In the third unsuccessful case the patient had hemiplegia and tertiary syphilis, in addition to his lung mischief. The amyl was taken in drop-doses for eight nights and seemed rather to increase than to diminish the amount of perspiration; in this case, too, oxide of zinc was given without benefit.

In the remaining fourteen cases the treatment was successful. The most striking case was that of a young man who had suffered severely from night-sweating for six weeks. A single dose of the amyl stopped them at once and completely for a fortnight. The perspirations then returned, and a single dose again kept them in check for a fortnight. For the third time this was tried, and with like result. It may have been a mere coincidence, but it certainly appeared to be the result of the treatment. In the majority of cases the treatment was less successful. Usually on the first night little or no benefit was experienced, on the next night the perspiration was less, and it gradually decreased in severity night by night till at the expiration of a fortnight it had nearly, if not wholly, ceased, and the patient was able to discontinue the medicine. At the expiration of about a week the perspiration would return, and it would be necessary to give the medicine again. One of these patients had renal disease in addition to the lung mischief, and another had frequent hæmoptysis. The others were simple cases of phthisis. Most of them were able to take outdoor exercise, but two or three were confined to bed.

Nitrite of amyl is a good remedy for night-sweats, but for promptness of action is decidedly inferior to atropia and other remedies.—*Practitioner*, August, 1879.

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Martellement.—The tribunals of the Seine Inférieure have recently been occupied with a curious case relating to the voluntary mutilations which young men practise upon themselves in order to escape the conscription. This operation is termed *martellement*, and consists in producing the deformity of one or more toes by causing a contraction of the flexors, the individual so operated upon walking on the ends of his toes instead of supporting himself on his plantar surface. As the result of an inquiry that has been instituted, it appears that *martellement* has been practised in the locality for more than forty years, and that since 1839 all the conscripts, with the exception of three, have gained exemption. No information has been obtainable as to the mode in which the operation is performed. The young man who was accused, formerly a good walker, has of late seldom left the house, and for some months has ceased to appear at the village balls; and on examination it was found that he had recently undergone *martellement.*—*Med. Times and Gaz.*, Oct. 18, 1879, from *Méd. Rév.*, Oct. 11.

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A Fever Bed.—The Medical Officer of Health for Bristol, Dr. Davies, has reported an outbreak of typhoid fever in that city, distinctly traceable to contaminated milk supplied to the retailers from a Gloucestershire farm, where the water-supply came from a polluted well situate in the midst of manure in all stages of decomposition, the water itself throwing off large quantities of sulphuretted hydrogen gas. The surroundings, Dr. Davies states, were totally unfit for a dairy, and the water simply poisonous.—*Med. Times and Gaz.*, Oct. 18, 1879.

Physiological Effects of Artificial Ischæmia.—The effects, on the functions of the part, of the application of Esmarch's bandage to the upper limb have been investigated by S. FUBINI, who has published the result of his researches in Moleschott's *Untersuchungen zur Naturlehre*, Band xii. He has arrived at the following conclusions, derived from observations made on a strong young man aged 20. 1. When the hand and forearm are brought into a state of bloodlessness by the application of Esmarch's bandage, the limb undergoes a diminution of volume, which, in the subject of the experiment, amounted to 62 cubic centimetres of water, at the temperature of 86° to 95° Fahr. 2. The ischæmia may last from 30 to 35 minutes, and exceptionally as long as 45 minutes. 3. The average loss of heat in the ischæmic part (hand and forearm) may be estimated at about 7 degrees Fahrenheit. 4. With the duration of the ischæmia, the temperature of the limb continues to fall; so that, at the end of twenty-five minutes, the reduction may be as much as 12.5° Fahr. On the other hand, there is a rise of about 2° and 3.5° Fahr. in the corresponding limb of the opposite side. After the cessation of the ischæmia, there is a fall of about 5.5° to 7° Fahr. in the temperature of the unbandaged arm; while the temperature of the limb that has been rendered ischæmic increases, and in about fifty minutes regains its original height. 5. The ischæmic limb rapidly loses its tactile sensibility and sensibility to pain. The power of perceiving differences of temperature disappears more slowly; indeed, the ischæmia cannot be continued long enough to produce complete insensibility to thermic irritants. 6. Tactile anæsthesia and analgesia appear more quickly in the peripheral than in the central parts of the ischæmic limb. 7. The muscular power, when tested by Regnier's dynamometer after the ischæmia had lasted twenty minutes, was found to be reduced to nearly one-half of its original value. 8. During ischæmia, the hand and forearm excrete less carbonic acid than under normal conditions, the proportion being 100 to 148.—*British Med. Journal*, Oct. 4, 1879.

Accident with Paquelin's Thermo-Cautère.—In the *Lyon Médical*, September 21, an account is given in which this instrument was employed for the purpose of cauterization in a case of diseased knee-joint. Ether was used as an anæsthetic, and the surgeons present were quite aware that accidents had before occurred from this taking fire. They were therefore on their guard, opening the window of the apartment (about sixty cubic metres in size), and keeping the vessel containing the ether at a distance from the cautery. The anæsthetization was tedious, so that 150 grammes had been employed, and a new bottle was just commenced with, when inflammation of the vapour in the room took place without any detonation, and the patient and doctors were enveloped in flame. Before this could be extinguished the patient was slightly and one of the doctors severely burned, and the bedclothes were set fire to. The patient never awoke, and the operation was terminated notwithstanding the accident. —*Med. Times and Gazette*, Oct. 4, 1879.

Colour-Blindness among Seamen.—In January, 1877, the Board of Trade issued instructions to examiners for masters' and mates' certificates, directing that the candidates should be subjected to a test examination as to their ability to distinguish colours. A return issued yesterday shows that the number of candidates who failed to pass the test between May, 1877, and May, 1879, was 39. Of that number, however, 12 passed upon re-examination, and one was allowed to have passed without any further examination. In four cases the candidates were unable to distinguish colours, and in one case no particulars were given. Green was in twenty-five cases described as red, in five as yellow, in six as blue, and in five as other colours. Red was in twelve instances described as green, three times as blue, and once as another colour. Yellow was mistaken for green eight times, and for red eleven times. Blue was confounded once with green, once with red, once with yellow. Black was twice taken for green, and twice for red; and white was twice described as green.—*Edinburgh Med. Jour.*, Nov. 1879.

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